The Effects of Childhood Sexual Abuse on Men.

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ABSTRACT

The aim of this thesis is to describe the effects of childhood sexual abuse on men. Childhood sexual abuse has not been well researched in this country.

Using the participant - observer method of study, a group was seen as the best avenue for research. It was decided to do case studies of the men involved in the group, this was to gain a better understanding of the dynamics both sexual abuse and the men in the group. Qualitative research methods are employed, this helped in two ways: 1) the data was reported without inappropriate interpretation: 2) This allowed the men to participate in the research rather than just being subjects. The men in the study became part of the research process rather than just subjects, they were consulted at each stage of the research process which they found very empowering, part of this empowerment was because the group had helped them to relate better and had shown them, that they were not alone.

This thesis is not concerned with theory construction, as it is a preliminary study. Theory will emerge as this and other data accumulates.The effects described by the men mirror those described in studies from overseas. All the men were abused by someone close to them, and all suffered in silence as children. They have all shown signs of psychiatric disturbance such as substance abuse disorders, suicidial ideation, depression and anxiety. Sexual dysfunction was rare, being reported in only one case however all acknowledged some form of overactive libido. Other effects were reported by the men and the group was used to explore these issues.

INTRODUCTION

REVIEW OF MALE CHILDHOOD SEXUAL ABUSE LITERATURE

Introduction

By way of introduction this review will start by addressing child sexual abuse in New Zealand in order to give a feel for what is happening in our own country. After the introduction, this review will concentrate on male child sexual abuse. By way of comparison this will include many reports on female child sexual abuse.

There is an obvious lack of research on child sexual abuse as a whole, mainly because of the denial and shame which accompanies such abuse. The research on men has been even more scarce than that on women mainly because men were seen as the abusers and not the victims. This view is changing.

This review follows the headings of Watkins and Bentovim's (1992) recent review. This is because their framework enabled the material to be presented in an obvious and logical manner which makes good sense of the literature.

Child sexual abuse

Professor Heger (an overseas expert on sexual abuse) said "she had seen an enormous increase in violence in New Zealand since her first visit four years ago .... She believed dysfunctional families, where children had often been either physically

or sexually abused, were a major contributor to the country's increasing brutality" (N.Z. Herald 19.2.92, cited in Bridgman, 1992 b).

Professor Heger also told a seminar on the topic that all prisoners in the United States were abuse survivors. Her view was that the New Zealand Government must make children a top priority if increasing violence is to be reversed (Dominion, 17.2.92).

New Zealand is in the middle of an epidemic of child sexual abuse. The monetary cost alone of this "disease" as a result of damaged and incapacitated lives must be huge (Bridgman, 1992b).

As child sexual abuse becomes more widely discussed by the public, and its extent given more publicity in the media, the nature of its dimensions are slowly beginning to emerge. For this reason, statistics about its prevalence are changing as the willingness of victims to talk about their experiences increases.

In a survey of school pupils in the Wellington district in the early 1980's, it was found that 38% of girls and 12 % of boys were aware of experiencing at least one incident of unwanted sexual touching. Five percent of girls under 16 had been raped (McKenzie cited in Saphira, 1987).

In a 1991 survey conducted in Otago (Mullen *et al.*, cited in Bridgman, 1992 b), 25% of the women surveyed reported being sexually abused as children, 8% by a relative. For 28% of these women, this was the first time they had revealed to anyone that they had been abused. Twice as many women as in a survey 4 years earlier

reported experiencing "genital abuse".

The Otago study also reported that 25% of women had experienced adult sexual abuse, and 29% physical abuse. Overall, 32% of women had suffered some form of abuse as children. It would be interesting to do a similar survey with men. None have been done as yet.

Overseas studies, where the statistics are much higher than those quoted here, suggest that the full extent of the problem may still be worse than these New Zealand statistics show (Kilgore, 1988). Research in New Zealand suggests the effects on victims to be much the same as found in overseas studies (Andrews & Merry, 1987; Jackson, 1980; Swan, 1986).

U.S studies suggest that as many as 80% of people in prisons have been the victims of child abuse. These people often develop "acting out" behaviours which are resistant to therapeutic efforts in adulthood. These people are in fact hitting out at society and authority in retaliation for their childhood victimisation (Abbott, 1985).

Van Dadelszen (1987) studied the frequency of sexual abuse among girls in the care of the Department of Social Welfare. Two thirds of these had experienced sexual abuse, half of them more than once. Half of the abusers were family members, a fifth friends or acquaintances, and only a tenth were strangers.

Victim characteristics are also typical amongst other members of dysfunctional families where abuse is occurring. Characteristically these families lack communication and affection, are socially withdrawn or isolated, physically unwell,

often violent, do not solve problems well, and are more often reported usually by the mother as dysfunctional in some respect (Garbarino, 1979; Hoagwood, 1990; Hoekstra, 1990; Western, 1985).

There is as yet many questions to be answered about abuse in New Zealand. Very little research has been done on men in New Zealand. This present study is among the first as far as this author is aware, and the findings support findings from overseas.

The following is a review of the overseas literature on male childhood sexual abuse. If stringent research design criteria were used to select studies many would have been omitted. However one aim of this thesis is to value evidence other than that which strictly adheres to orthodox empirical methods as useful in researching and understanding the problem of sexual abuse.

Definition

There are many problems in defining sexual abuse. One definition which has been widely accepted is due to Schechter and Roberge (1976). They defined sexual abuse as "The involvement of dependent developmentally immature children or adolescents in sexual activities they do not truly comprehend, and to which they are unable to give informed consent and that violate the sexual taboos of family roles". This definition is designed to cover incest and if the last part of the definition is dropped (that violate the sexual taboos of family roles) this covers abuse outside

the family. Many researchers usually add an age differential between the abuser and victim of 5 years or more (Watkins & Bentovim, 1992). Johnson (1988, 1989) has suggested setting this differential to 2 years, along with other criteria, as there has been growing evidence showing that abuse between children of similar ages can be just as traumatic. In fact Cantwell (1988) supports this suggestion and advocates a definition of abuse entirely based on behaviour, excluding age difference factors altogether. For example, oral-genital contact or penetration of the vaginal/anal opening with fingers or objects would be regarded as abnormal and abusive .

However what distinguishes the boundary between abusive and non-abusive sexual contact with children remains. This would partly be in the perception of the victim and the abuser, yet some behaviours are clearly abusive. Sexualized attention has been put forward as a term to describe this fuzzy boundary (Haynes-Seman & Krugman, 1989). There is obvious abusive behaviour such as masturbating, anal fingering or intercourse, but caressing and stroking buttocks persistently, or poking fingers in the mouth, which may be arousing to the abuser, would be examples of what was considered as sexualized attention. The abusive aspect depends on the affective state of parent and child, and whether the child has a sexual response to it. This clearly fades into more normal behaviours. Rosenfeld, Siegel, & Bailey (1986) study showed that more than 50% of 8- 10-year old daughters were reported as touching their mother's breasts and genitals, and more than 30% to be touching their father's genitals, while more than 40% of 8-10-year

old sons were reported as touching their mother's genitals and about 20% their fathers genitals. This raises several questions. What is normal sexual behaviour in children? What effects at different ages, if any, does modelling of sexual behaviours have? What constitutes abusive modelling? Faller (1989a); Seghorn, Prentky and Boucher (1987), and Smith and Israel (1987) say this is an important factor, but as yet remains unresearched due to ethical and design problems.

Prevalence

When asking about prevalence rates the first consideration is how the definition of abuse, sample population, and interview method can affect the prevalence rates found. Peters Wyatt and Finkelhor (1986, cited in Watkins & Bentovim 1992) have reviewed the prevalence of child sexual abuse comparing males to females. They examined volunteer samples (Hamilton, 1929; Kinsey, Pomeroy, Martin & Gebhard, 1953; Landis *et. al.* 1940); college student samples (Finkelhor, 1979; Fritz, Stoll & Wagner, 1981; Fromuth, 1983; Landis, 1956; Seidner & Calhoun 1984) and community samples (Badgley *et al.*, 1984; Bagley & Ramsay, 1986; Burnam, 1985;Finkelhor, 1984d; Keckley Market Research, 1983; Kercher & McShane,1984; Lewis,1985; Miller, 1976; Murphy, 1985; Russell, 1983; Wyatt, 1985). These studies were all North American. The authors found considerable variation in the prevalence rates for child sexual abuse in these studies. Reported ranges were from 6% to 62 % for females and from 3% to 31% for males. These rates indicate at the least a major problem at the most a major epidemic. One wonders what role sexual abuse plays in mental illness. Of the "ex-patients" I have seen in clinical settings all have said that they and the other patients they have talked to had been sexually abused.

The resource implications of these figures are immense and, as Zeitlin (1987) points out, thought must be given to the impact sexual abuse has before proposing any intervention which might itself have long-term harmful effects. This is not to

condone less harmful variants of sexual abuse or to ignore the risk that such variants may progress to more harmful forms of abuse. Two American studies (Fritz, Stoll, & Wagner 1981; Fromuth & Burkhart, 1989) and one British study (Baker & Duncan, 1985) illustrate how the definition can affect the rates. These three studies were all retrospective. Baker and Duncan (1985) used a non-contact definition of abuse, and found a rate for men of 8%. Fritz *et al* (1981) used a contact definition of abuse in their college student sample and found a rate of 4.8% in men. When Fromuth and Burkhart (1989) included both contact and non-contact definitions of abuse in 684 college men from two sites the rate of abuse trebled to 45% in one group and 13% in another as the definition became less restricted. Fromuth and Burkhart considered a more conservative estimate of 2-3% prevalence to be more appropriate considering the inconsistencies they found when using broader definitions. All three studies report that the effect on men was either minimal or less than in sexually abused women. Baker and Duncan (1985) do not discuss how denial might confound the finding that the same proportion of adults abused just once (43%) and those repeatedly abused by multiple abusers (42%) report no effect. Watkins and Bentovim (1992) suggest future surveys need to address the problem of separating denial of adverse effects from valid negative answers.

Finkelhor (1984b), when he adjusted prevalence rates to include contact experiences and an age discrepancy, found the rates dropped from 8.7 to 4.1% and

6 to 3.2% for men abused as children. As has already been pointed out age discrepancy may be misleading in looking at abuse. It is of major concern that a child in need of help may be overlooked due to age discrepancy.

When looking at the clinical setting a different picture emerges. In this setting the figure is typically higher than in community based settings. Pierce and Pierce (1985) found that 12% of callers to a sexual abuse hotline were male. Dejong, Emmett & Hervada (1982) showed 14% of cases reported to a hospital assault unit to be male, Reinhart (1987) reported this figure at 16%.

The problem of under-reporting follows from these figures, especially when one considers that research shows an increase in the numbers of cases being reported that involve boys (e.g. Hobbs & Wynne 1987)

Ratio of abuse: boys to girls

Community studies have found prevalence rates of abuse in the order of 2-4 girls to 1 boy (Badgley *et al.*, 1984; Burnam, 1985; Murphy, 1985 all cited in Watkins & Bentovim 1992; Finkelhor, 1984d; Kercher & McShane, 1984;), although some have found this figure to be lower (e.g. Baker & Duncan, 1985; Lewis, 1985; Keckley Market Research, cited in Watkins & Bentovim, 1992) all of which found ratios of about 5 to 3.

Clinical studies are not so uniform, ranging from 2.2 girls to 1 boy (Hobbs & Wynne, 1987) to the old 9 to 1 ratio previously believed to be true (e.g. Cupoli &

Sewell 1988; Dube & Herbert, 1988) The continuing discrepancy between community and clinical study ratios demands further exploration and explanation (Watkins & Bentovim 1992).

Prevalence of sexual abuse in special Populations

Watkins and Bentovim report on several different populations where the nature of the research is limited and very underdeveloped. These are: (1) runaway populations; (2) male prostitutes; (3) male only children's institutions; and (4) inpatient psychiatric populations.

Generally, little has been done on these areas, except for the inpatient settings which show an increase of cases reporting sexual abuse in children. Little has been done regarding adults however. (Emslie & Rosenfeld, 1983; Husain & Chapel, 1983; Kolko, Moser & Weldy, 1988; Livingston, 1987; Sansonnett-Hayden, Haley, Marriage & Fine, 1987; Singer, Petchers & Hussey, 1989).

Under-Reporting

Peake (1990a) derived a figure of 0.3% from a projection of cases reported to professionals (Mrazek *et al.*, 1981 cited in Watkins & Bentovim 1992).

Watkins and Bentovim (1992) look at possible factors that effect the under-reporting of boys specifically. They group them around two areas; individual factors which come from the boy; and those due to a lack of response from those around him.

Individual Factors

(A) Fear of homosexuality

Finkelhor and Browne (1986) have drawn attention to the `male monopoly' amongst sexual abusers. This is promoted by the abusers in order to keep the victims quiet and revolves around an intense fear of homosexuality, or being labelled as such. Watkins and Bentovim (1992) say that it is a common clinical experience for boys to feel, because they responded to the abuser, that the abuser had recognised them as being somehow gay.-Nathanson (1989) believes shame is a powerful factor in preventing disclosure, and this is used by the abuser to maintain dominance over the abuser.

(B) Differential emotional response

This refers to whether boys are more likely to `act out' (externalize) or `act in' (internalize) than girls. Within the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-111-R) American Psychiatric Association(1987) disruptive behaviour disorders (externalized) are much more common amongst boys than girls, whilst anxiety and depressive disorders (internalized) are either equally likely or more common amongst girls. There is insufficient information to determine gender differences in regard to post-traumatic stress disorder and adjustment disorders. Distressed responses tend to elicit more sympathetic and concerned inquiry than do `acting out' responses.

Kaufman (1984) and Kaufman, Divatso, Jackson, Voorhees & Christy (1980) have provided some support for the notion that boys are reluctant to share their abuse. Some of their subjects were adolescents. They noted that when women are raped, about half show what is described as an `expressive' rape trauma syndrome and about half a highly `controlled' rape trauma syndrome. Kaufman's, in contrast, found only 20% of males showed an `expressive' response, whereas 80% showed a `controlled' response. Also male victims would not tell of the rape when in hospital complaining of other injuries and it was only the alertness of the professionals present which enabled them to share that they had indeed been raped.

However, the effects literature on sexually abused boys does not, as yet, provide support for the hypothesis that externalizing responses occur more commonly in boys. This will be discussed further below (Watkins & Bentovim 1992).

Lack of Response

(A) Lack of supervision

This is in regard to older boys within the community who are too old to really need looking after which may in turn make them more vulnerable to abuse. This harks back to ethos of self reliance. However, this factor fails to show up in child protection or even clinical reports from e.g. hospitals, because police fail to refer on such children (Watkins & Bentovim 1992, Finkelhor, 1984a,b,c).

Most of the evidence available does indeed suggest extrafamilial abuse is more common in boys (Baker & Duncan, 1985; Faller, 1989b; Finkelhor, 1984b; Rogers & Terry, 1984; Vander Mey, 1988), but is divided over whether boys are more prone to abuse by strangers.

(B) Blaming the boy

Pierce and Pierce (1985) put forward the notion that under-reporting in boys may be linked to the self reliant ethos, where boys are taught to be tough and to take care of themselves, it is their own fault if they put themselves at risk. They thus need punishment rather than help. However, Finkelhor's (1979) finding shows that, irrespective of the child's gender, over 90% of abusive acts were initiated by the adult abuser, not the child, and that even if the blaming mechanisms differ for boys and girls it remains false to blame the child.

Indirect evidence to support a blaming hypothesis was presented by Broussard

and Wagner (1988) where they examined the attitudes of undergraduates to several sexual abuse scenarios. The scenes involved a 15-year old victim, but varied by sex of perpetrator, sex of victim, and whether the child was encouraging, passive, resistant, or upset. Male respondents rated the abuser less responsible whenever the victim was male (rather than female), and least responsible when the male victim was encouraging. They concluded male victims were penalized more by male respondents and while not overtly blaming of them, this adds weight to the blaming hypothesis.

(C) Missing alerters more pertinent to boys

Sebold (1987) suggests several indicators which he has found from clinical experience may indicate sexual abuse. These are homophobic behaviour, exhibitionism and sexual offending in preadolescent or adolescent boys.

Several authors have shown that boys don't get abused in isolation but in conjunction with their sisters, (Bentovim, Boston, & Van Elburg, 1987; Faller, 1989b; Finkelhor, 1984b; Pierce & Pierce, 1985; Vander May, 1988), so the abuse is often disclosed by a third party rather than the boy (Reinhart 1987). Sexual abuse of a sister is a clear indication to interview brothers. This may contribute to under-reporting.

(D) Denial of abuse by females

This has almost been a taboo subject. With the rise of the feminist movement men were the abusers and women were not. So strong was this belief that Rosenfield as late as 1979 reported that in "mother- son incest one or both of the parties is psychotic". McCarty (1986) disproved this notion finding only two of eight women in mother-son incest to have emotional disturbances. However more and more evidence is coming to light which shows the reporting of women abusing is increasing. A recent FBI survey showed 60% of convicted rapists were abused by women. So, the number is small but growing. Bentovim *et al.*, 1987; Faller, 1989b say the rate coming to the notice professionals is between 5% and 15% Dimock (1988) found 28% were abused by women- 20% if only those acting in isolation are considered. McCarty (1986) reported 43% of those abused in mother-child incest were sons, while Fehrenbach and Monastersky (1988) found 40% of the children abused by female adolescent perpetrators were male. Johnson (1989) reports a ratio of 2 boys abused to 1 girl by a female perpetrator.

Two studies report higher numbers of children abused by women than men. Fromuth and Burkhart's (1989) study of college men found over 70% of those reporting sexual abuse were abused by women. Fritz *et als* (1981) study with a college sample, which reports similar findings- 60% of the perpetrators were female. In defence of their findings both studies suggest it is clinic samples which have been biased towards male perpetrators. Replication is obviously required

(Watkins & Bentovim 1992).

The final aspect of this relates to the men-only-perpetrators belief. McCarty (1986) notes an attitude of "women being viewed as sexually harmless to children: what harm can be done without a penis?". This results in a fear of disbelief of abuse by females. However this attitude is changing as the recent Oprah Winfrey special on sexual abuse went to great lenghts to show women abuse as well. This fear is still very strong. Recent studies by Krug (1989) and Singer (1989) have found only one man in their respective studies of eight and 12 victims who had actually reported their abuse by a family relative. Faller (1989b) found boys were 10 times more likely than girls to be abused by a woman alone. Banning (1989) argues that due to the changing role of women in our society we will see an increase in the incidence of women abusing.

(E) Denial of father-son abuse

A number of reports have stated that fathers followed by step-fathers are the biggest abusers of sons (e.g. Faller, 1989b; Hobbs &, Wynne, 1987; Pierce & Pierce 1985; Reinhart, 1987). But there is a surprising lack of research in this area. Justice & Justice (1979, cited in Watkins & Bentovim 1992) who started to look at father-son abuse in depth, explain this striking denial in terms of "two moral codes: the one against incest and the one that has previously existed against homosexuality".

Some reports have found an association between physical and sexual abuse of boys (Cavaiola & Schiff, 1989; Finkelhor, 1984b; Kolko *et al.*, 1988; Sansonnett-Hayden *et al.*, 1987) particularly with father-son incest (Dixon *et al.*, 1978), which may be of use in detecting this kind of abuse.

Pierce (1987), in her survey of the literature, could find only 52 instances of father/stepfather sexual abuse reports. She describes three types of families where father-son abuse occurs: homosexual families (although overt homosexuality featured in only six of the 52 cases); promiscuous families, where sexual abuse occurs with several children (this had the highest number of cases by far); and physical abuse in a family (this accounted for 20% of the cases of sexual abuse reviewed). In the main paedophiles indicate a preference for boys. Righton, (1981 cited in Watkins and Bentovim 1992) and Finkelhor (1984b) concluded that victimized boys are more likely than girls to come from impoverished and single-parent families. Peake, 1990a states a proportion of all abusers choose their families, their jobs and their friends so as to gain access to children.

(F) Denial of child-child abuse

This form of incest is thought to be most common(De Jong 1989). This recent research has begun to recognize the need to understand the effects of sibling and cousin incest, of child-child and adolescent-child sexual abuse (e.g. Cantwell, 1988; Chasnoff, Burns, Schnoll, Burns, Chisum, & Kyle-Spore, 1986; De jong, 1989;

Friedrich, Beilke & Urquiza, 1988; Johnson, 1988, 1989; Smith & Israel, 1987). These studies involve over 150 examples of child-child abuse and show an overlap between the various forms of abuse. In one centre child perpetrators are presenting at the rate of three to four each week (Cantwell, 1988).

This has some implications for the age criteria in defining abuse. How young can a child be and be an abuser? This is like asking how young can a child be held accountable for their actions? These are questions yet to be answered.

Chasnoff et al. (1986) describe a boy, whose abuse stopped by the age of 9 months, who, at 25 months, was demonstrating "sexual aggressiveness" towards other children. Pertinent questions here are: When does 'sexualization' or 'acting out' become abuse? Should we relabel it?

The Effects of Sexual Abuse

Sadly the specific effects on boys of sexual abuse is not well researched. This is due mainly to the under-reporting of abuse in boys. The effects on girls has been well researched. Whether the effects are different or not has yet to be seriously researched. Matching the boys and girls in terms of demographics, nature of abuse and abuser is difficult.

The effects of sexual abuse are considered from both childhood (initial effects) and adult (longer term effects) perspectives, as age does make a difference. The younger child is more likely to have a regressive response following sexual abuse

due to his/her immaturity, while an older child might run away or take drugs. How the family responds to the revelation of sexual abuse may also have a strong influence on the subsequent course of any reaction (Watkins & Bentovim 1992).

Both Friedrich *et al.* (1988) and Rogers and Terry (1984 cited in Watkins & Bentovim 1992) have suggested that greater initial symptomatology is associated with greater severity of abuse. However clinical practice has not confirmed this (Pow 1986). Wyatt and Powell (1988) have found abuse by (a) fathers, (b) genital contact and (c) the use of force, have affected the symptomological outcome, with (b) and (c) being aspects of 'severity'. Sirles, Smith and Kusama (1989) report that the presence of an Axis 1, DSM-III diagnosis relates to older victims, a closer relationship of the offender to the child, greater frequency and longer duration of abuse.

General initial effects

Tong, Oates & McDowell (1987) assessed children 2.6 years after their initial assessment for abuse found that girls exhibited more problematic behaviour than boys and the boys self esteeem was no lower than for controls. This finds support from the self-reports of men who say they suffered fewer symptoms as a result of childhood abuse.

The finding of boys having fewer symptoms than girls has some support from a study by Kiser, Ackerman, Brown, Edwards, McColgan, Pugh, Purrit, (1988) who

assessed five boys and five girls involved in a day care centre. They found boys showed greater effects at first, but after a year, follow up suggested girls exhibited greater symptomology.

Specific effects

Rogers and Terry (1984 cited in Watkins & Bentovim 1992) describe behavioural responses which they saw as more or less unique to male victims, these are: (1) confusion/anxiety over sexual identity; (2) inappropriate attempts to reassert masculinity; and (3) recapitulation of the victimizing experience.

Confusion over sexual identity

Many boys feel as though they have been selected because the abusers noticed something about them which implicated they were Gay. This can be compounded if they do not resist or they get aroused by the abuse. Sebold (1987) interviewed 22 therapists working with sexually abused boys found a high concern over sexual identity, mainly of a homophobic nature. Pierce (1987), in her review of father-son incest, cites some cases where anxiety over being homosexual occurs, ranging from the chronically neurotic to mildly anxious.

The question remains, does child sexual abuse contribute to a homosexual preference? Some studies support this notion to an extent showing a greater likelihood of developing a homosexual preference, especially those boys abused by

males (Finkelhor, 1984c; Johnson and Shrier, 1987). This is supported by a number of studies which report a concern over sexual preference in a significant minority of abused men (Bruckner & Johnson, 1987; Dimock, 1988; Krug, 1989; Singer, 1989). Krug's (1989) sample includes abuse by mothers.

Fromuth and Burkhart (1989) found there was no difference in reporting of homosexual experiences after the age of 12 between abused and non-abused college men. However their sample included a majority of female perpetrators so the sexual identity problem may not show. Male perpetrators are implicated in the above research.

Further support from this comes from work with gay men who report they have not had inappropriate experiences in childhood themselves, and secondly, only a minority of homosexuals have a sexual interest in children (Finkelhor, 1984c; Newton, 1978). It is dangerous to equate a homosexual abusive act with an assumption that the perpetrator is homosexually orientated (Watkins & Bentovim 1992).

Inappropriate attempts to reassert masculinity

Rogers and Terry (1984 cited in Watkins & Bentovim 1992) believe this is the most common symptom for boys who have been abused. Postabuse the child displays a lot of aggressive behaviour, such as picking fights, destructiveness, disobedience, and a generally hostile or confrontative attitude. Other authors share

this view (e.g. Summit 1983). However the research in this area doesn't support these views.

Many studies have used the Child Behavior Checklist (CBCL) of Achenbach and Edelbrock (1983) to evaluate the effects of childhood sexual abuse. These studies include Friedrich,(1988); Friedrich *et al.*, (1988); Kiser *et al.*, (1988); McLeer, Deblinger, Atkins, Foa, & Ralphe, (1988); and Tong *et al.*, (1987). This instrument places child psychopathology within two broad factors-internalizing and externalizing. Freidrich *et al.* (1988) compared sexually abused boys with those with oppositional or conduct disorders. They found the sexually abused boys to be significantly less externalizing or aggressive but to have more sex problems. McLeer *et al.* (1988) found elevated CBCL scores when suffering from post-traumatic stress disorder. Other general findings from the other above authors include sexually abused children are:

1). More likely to score in clinical ranges than community controls;

2). Likely to have total scores in the same range as psychiatrically referred but non-abused children;

3). Likely to have elevated scores on both externalizing and internalizing measures.

If Rogers and Terry's view is correct boys would be expected to score higher on the externalizing measures. This was not shown.

Some support for the question of men externalizing was obtained from the Los Angeles Epidemiologic Catchment Area Study, involving a randomly selected

community sample (Stein, Golding, Siegel, Burnam & Sorensen, 1988, cited in Watkins & Bentovim 1992). Sexually abused men tended to have "acting out" psychiatric diagnoses, such as drug abuse or dependence.

Recapitulation of the victimizing experience

A tendency among boy victims to recapitulate their own victimization, only with themselves as the abuser and someone else the victim has been shown with in the literature (Rogers & Terry, 1984 cited in Watkins & Bentovim).

Conte and Schuerman's (1988, cited in Watkins & Bentovim) shows that children victimizing others is uncommon. Sexually victimizing others ranks 31st (2%) out of 38 symptoms. The drawback to this report is there is no gender breakdown. Other reports which focus on boys show a significant proportion of victims had become perpetrators. Sansonnett-Hayden *et al.* (1987) report three (50%) out of six abused adolescent boys became perpetrators. However this study can hardly be called representative if only six subjects were studied. Friedrich *et al.* (1988) found four (13%) out of 31 boy victims had become perpetrators by the age of 8. If these findings were rank ordered with Conte and Schuerman's (1988) symptom list, boys going on to become perpetrators would then become the fourth most common symptom (Watkins & Bentovim 1992). Obviously, the above information is hardly well researched or conclusive,indicating a need for more research.

Finkelhor (1986) argues against the use of a single-factor theory where victims become victimizers. He believes it is exaggerated, it ignores sociological aspects, it might strike terror into the hearts of victims and that, worst, it might become a self-fulfilling prophecy. Add to this the fact that not all abusers are themselves abused and this approach shows up as being of poor strength. Even with the research already done it is obvious that most abused boys do not become abusers. Reports with groups of men show that although they may not become abusers most of the men have had to confront this problem on their way to healing (e.g. Singer 1989; Dimock 1988)

Recent reports of boys and male adolescents who abuse show a significant proportion have been abused. Both Becker (1988 cited in Watkins & Bentovim 1992) and Fehrenbach, Smith, Monastersky, & Deisher (1986) found rates of 19% had a prior history of sexual abuse in a total of 422 adolescent offenders. Other reports have shown a much higher rate. Smith and Israel (1987), found 52% of their sibling perpetrators sample had previously been abused; Johnson (1988) found 49% ; Katz (1990) found 61% of 31 molesters and Longo (1982) reported 47% of her male child perpetrators had been previously abused. Finally, Katz (1990) found 61% of 31 molesters in a residential treatment programme for molesting adolescents reported previous molestation of themselves.

The findings for girls and women are even more dramatic. Three reports have the following figures: 50% for Fehrenbach and Monastersky's (1988) 14 female

perpetrators, 75% of McCarthy's (1986) study, and all of Johnson's (1989) female perpetrators had been abused. These figures may be upwardly skewed when the fact that women abusers are a smaller population compared to men is kept in mind.

The effects on adults is very similar as that for the children. Groth & Burgess,(1979) found 32% of 106 child molesters had been abused, while Pithers, Kashima, Cumming and Beal (1988) found 56% of 135 paedophiles and only 5 % of 64 rapists had histories of childhood sexual victimization. Both Freeman-Longo (1986) and Friedrich *et al.* (1986), believe that abuse of long duration or abuse by multiple abusers increases the chances of the boy victim becoming an abuser. Russell and Finkelhor (1984) associate this perpetrator risk with more severe, more unusual and more disturbing abuse.

Becker (1988, cited in Watkins & Bentovim 1992) proposed a broad model to explain the development of a perpetrator. This includes individual, family and social variables which will interrelate:

A). Individual - Social isolation

Impulse control disorder

Conduct disorder

Limited cognitive abilities

History of physical/sexual abuse

B). Family-Parent(s) engage in coercive sexual or physical

behaviour towards other in family

Family belief system supportive of coercive sexual behaviours

Parents have poor interpersonal skills and lack empathy

C). Social- Society supportive of coercive sexual behaviour

Society supportive of the sexualization of children

Peer group behaves in an antisocial behaviour

In summary, current evidence supports the belief that the sexual abuse of boys in childhood is an important contributing, but not a necessary, factor in the development of a perpetrator. For girls, this may have some effect although there is less evidence to support this. Therefore, any child referred because of abusive behaviour towards others should be assessed as they may have been abused themselves.

Other factors

Other effects noticed by various authors include physical trauma and the removal of boys from the home. Physical trauma occurs in 24 - 68% of boys from reports carried out in hospital settings (DeJong *et al.*1982; Ellerstein & Canavan 1980; and Spencer & Dunklee 1986). The most common types of trauma reported are lesions, bruises, genital and anal injuries. Reinhart (1987) found injuries more consistent with sodomy in older boys and "abnormal anogenital" findings in

younger boys. Finally, boys are less likely to be taken from the home (Pierce & Pierce 1985). Richardson(1990) suggests three possible reasons why;

1). Fathers are more likely to be removed from the home and persecuted. 2). Mothers may be less threatened by a Homosexual act taking place in the home as this does not necessarily reflect on her performance. 3). The societal belief that males are more able to protect themselves.

Long-Term Effects

Watkins and Bentovim (1992) prepared a table showing support for and against various hypotheses regarding long-term effects this table is reproduced here as Table 1.

Table 1

Hypothesis	Support	Unsupported
1. Initial effects		
Boys, like girls, commonly respond to abuse with sexualization	Friedrich *el al.* (1988); Gale *et al.* (1988); Kolko *et al.* (1988); Mian *et al.* (1986); Rogers & Terry (1984); Sebold (1987); Tufts' New England Medical Centre (1984) Yates (1982)	
2. Longer term effects		
Male child/adolescent perpetrators have a frequent history of previous sexual abuse		

Hypothesis	Supported	Unsupported
	Becker (1988);	Jones *et al.* (1981);
	Cantwell (1988;	Pomeroy *et al.* (1981)
	Fehrenbach *et al.* (1986);	
	Friedrich (1988);	
	Johnson (1988); Katz (1990	
	Rogers & Terry (1984);	
	Sansonnet-Hayden *et al.* (1987)	
Adult sex offenders have a frequent history of previous sexual abuse		
	Faller (1989a);	
	Russell & Finkelhor (1984);	
	Freeman-Longo (1986);	
	Groth & Burgess (1979);	
	Longo (1982); Seghorn *et al* (1987)	
Sexually abused boys later have greater sexual identity confusion and an increased likelihood of a homosexual preference		

Hypothesis	Supported	Unsupported
	Bruckner & Johnson (1987);	Becker (1988);
	Finkelhor (1984c);	Fromuth (1989)
	Johnson & Shrier (1987)	
	Justice & Justice (1979);	
	Krug (1989); Singer (1989)	

3. Sexually abused adolescents/men

Have lower sexual self-esteem and/or greater sexual dysfunction

Finkelhor (1984c);	Fritz *etal.* (1981);
Fromuth & Burkhart (1989)	Fromuth (1983);
(premature ejaculation and erectile difficulty only);	
Johnson & Shrier (1987)	Stein *etal.* (1988)

Have an increased tendency towards compulsive sexuality

Hypothesis	Supported	Unsupported
	Dimock (1988); Krug (1989)	Fromuth & urkhart (1989)
Self-report less psychological harm	Baker & Duncan (1985); Catanzarite (1980); Fritz *et al.* (1981); Fromuth (1983)	Johnson & Shrier (1987)
Have a greater prevalence of depression compared to non-abused males	Briere *et al.* (1988); Dimock (1988); Krug (1989) Stein *et al.* (1988); Stiffman (1989); Swett *et al.* (1990)	Fromuth (1983)
Have increased suicidal feelings or behaviour	Briere *et al.* (1988); McCormack *et al.* (1986);	

Hypothesis	Supported	Unsupported
	Singer (1989)	
Have lower self-esteem than non-abused males		
	Cavaiola & Schiff (1989); Singer (1989)	Fromuth (1983); Stiffman (1989)
Have an increased prevalence of anxiety disorders		
	Briere *et al.* (1988); McCormack *el al.* (1986); Stein *et al.* (1988); Swett *et al.* (1990)	Fromuth (1983)
Have increased relationship difficulties		
	Bruckner & Johnson (1987); Dimock (1988); Krug (1989); McCormack *et al.* (1986); Singer (1989)	

Watkins & Bentovim (1992) then go on to outline four questions they consider crucial in assessing the long-term effects on boys.

(1) Is there a demonstrable association between childhood sexual abuse and later psychological disorder, which significantly exceeds that of non-abused males? (2) If there is, has the disorder been continuously present or has its onset occurred later on in life? (3) What proportion of sexually abused males have an associated disorder, and does the proportion for each disorder differ between men and women? (4) Does the pattern of disorder/difficulty seen differ between men and women?

There are now enough studies to at least give a preliminary evaluation of these questions. One problem which has existed in the literature for some time has been the lack of a breakdown of the types of abuse that will give a picture of severity. The need to research the severity is based on the presumption that the more severe the abuse the greater the effects. This problem most likely reflects the shame men feel on disclosing and being involved in homosexualized abuse.

Baker and Duncan (1985) were, in their study, able to look at anal abuse. They found that intercourse rates of abuse for males and females were the same. However, despite equal rates of contact sexual abuse, males reported they were significantly less damaged by their abusive experiences than did females. This puzzled the researchers and in order to explain this they hypothesized that boys might more readily dissociate from the experience on the basis that it was abnormal male, parental, sex role behaviour. In children, Rogers and Terry (1984) and others

reach the opposite conclusion. It is the very nature of the homosexual act which they consider leads to the most psychological conflict.

Psychiatric disorders

Depression, suicidality, anxiety and substance abuse disorders have all been linked as outcomes associated with sexual abuse.

Stein *et al.*, (1988) asked their subjects about sexual abuse by defining it as "their touching your sexual parts, your touching their sexual parts, or sexual intercourse". They found sexually abused men scored higher life time and 6 month prevalence rates for any psychiatric diagnosis. The other major finding of this study was a greater frequency in men of substance abuse disorder and, at least on the lifetime prevalence figures, a greater frequency in men of antisocial personality disorder. These to disorders accounted for the excess in prevalence rates among men. Women, on the other hand, had higher rates of anxiety and depressive disorders than men and these were significantly more frequent than the non-abused women controls. There were no associations regarding schizophrenic disorders. These findings show what is thought to be traditional gender differences regarding psychiatric epidemiology.

Fromuth and Burkhart (1989) found no increased depression (as measured by the Beck Depressive Inventory-Short Form) in men predominantly abused by women.

Another psychiatric disorder described in the literature is the development of multiple personality disorder. Keys (1991) describes a boy who developed 24 personalities as a result of sexual and physical abuse by his father. Saltman and Solomon (1982) describe factors which contribute to the development of the disorder. These are family histories of enmeshment, seductive behaviour by a parent, double binds between parent and child, severe beatings, incest, and other forms of emotional and physical abuse.

A recent lecture given by an authority on MPD stated that the personality splitting occurred in response to severe trauma. He stated 75% of his patients had suffered some form of sexual abuse.

Finally, what do clinical reports present? Several clinical reports have found higher suicidal feelings than non-abused controls(e.g. McCormack, Janus & Burgess, 1989; and Singer, 1989). Two clinical reports are worth mentioning (Briere, Evans, Runtz and Wall, 1988; and Swett, Surrey and Cohen, 1990). Briere *et al* (1988) looked only at men who presented to a crisis centre suffering from the consequences of childhood sexual abuse. They found no gender differences with regard to the disorders presented, both sexes produced a similar range of symptomology. However all sexually abused people showed higher rates of trauma related symptoms as measured by the Trauma Symptom Checklist (dissociation, anxiety, depression, anger, sleep disturbance) than non-abused controls.

Swett *el al.* (1990), studied 125 men who had been abused either physically,

sexually or both. They found that symptom severity was significantly greater in those who were abused before the age of 18. Using the SCL-90-R they found, with one exception, the subscale scores for the sexually abused or both sexually and physically abused groups was higher than the physically abused only group.

In summary, sexual abuse does affect the likelihood of an associated psychiatric disorder. Although there is evidence to support differences between the sexes, with men more likely to develop depressive and anxiety disorders especially substance abuse, this is tentative and requires further investigation.

Substance abuse

Stein *et al.*, (1988), showed higher lifetime and 6-month prevalence rates of substances abuse among men. They also state that substance abuse disorder mostly accounts for the different gender prevalence rates.

Clinical reports, mostly uncontrolled, are unanimous in reporting that substance abuse problems are associated with sexually abused males (Bruckner & Johnson, 1987; Dimock, 1988; Krug, 1989; Singer 1989).

Cavaiola and Schiff (1989) looked at the difference between sexually abused and non-abused chemically dependent adolescents. They found that sexually abused adolescents (male and female) began using drugs and /or alcohol at a much younger age than the non-abused adolescents in the centre and a control group drawn from a local high school. Unfortunately they do not give a gender breakdown.

Sexual functioning

The effects of sexual abuse on sexual functioning are well known in women. This is not the case with men. All the reports show that abused men have some sexual problems but there is quite a range of problems mentioned. Fromuth and Burkhart (1989) found little in the way of sexual problems other than premature ejaculation in one group and erectile difficulties in the other. Pierce (1987) lists three studies where sexual difficulties, caused in part by homosexual feelings, were present in sexually abused men who had married.

Johnson & Shrier (1985) found male victims were more likely to identify as homosexual and be more at risk of sexual dysfunction. A later study by the same authors found sexually abused adolescents were seven times more likely to identify as homosexual and six times more like it to identify as bisexual.

Stein *et al.* (1988) reported twice as many sexually abused women as men reported a fear of sex, lower libido, and less sexual pleasure, on lifetime prevalence basis. McCormack *et al* (1986) found runaway sexually abused boys had no confusion concerning sex. This contrasts with runaway girls who report confusion regarding sex. However, Finkelhor (1984c) developed a "sexual self-esteem" measure and found sexually abused men scored lower than women, although both scored lower than controls.

Finally, Dimmock (1988) found sexual compulsiveness typified male abuse victims in his groups. This was characterised by a lack of control over one or more

sexual activities, such as, pornography, multiple partners, and sexual thoughts.

The results are very confusing. Tentatively, a trend toward lower effects in men than women with regard to sexual functioning seems to be emerging. This finding may reflect the differences in types of abuse between men and women, or it may be confounded by the "male-ethos". This is where men are encouraged to prove their virility with tales of their sexual exploits; add to this the fear surrounding homosexuality for so many sexually abused men and the results may be very difficult to interpret. Watkins & Bentovim (1992) note with concern that perpetrator risk has been excluded from this literature.

Self-esteem

Cavaiola and Schiff (1989) using the Tennessee Self-Concept Scale, were able to show that low self-esteem is one of the longer lived consequences of abuse. Stiffman (1989) was unable to replicate these self-esteem findings using a different inventory. Fromuth and Burkhart (1989) obtain a slight association between negative self-esteem and sexual abuse in men.

Relationships

Several clinical reports with men show that sexually abused men have great difficulty relating in intimate relationships (Bruckner & Johnson, 1987; Dimock, 1988; Krug, 1989; Singer, 1989). This stems from several possible cause; mistrust

of others, fear of intimacy, of making and breaking relationships abruptly, and from recreating abusive childhood patterns. All of these factors are likely combine into general difficulties with sexual relationships (Watkins & Bentovim 1992).

These difficulties may indicate a diagnosis, in some, of borderline personality disorder. Swett *et al.* (1990) noted an insignificantly increased rate of borderline personality disorder in a subsample of abused men, while Ogata *et al.* (1990) did not. Taken together these studies are inconclusive. Anecdotal, clinical evidence obtained from several Christchurch practioners would suggest the borderline personality disorder may be more widespread than previously thought among sexually abused people.

McCormack *et al.* (1986) report adolescent sexually abused males as having more difficulty interacting with friends, to withdraw from friends, to have difficulty with same sex friend relationships, and difficulty with opposite sex friend relationships. Compared to non-abused controls, abused adolescents had a significantly greater fear of adult men. However their study dealt with run-away adolescents and this may be a contributory and confounding factor.

It seems certain from the above findings that there are indeed relationship problems. Many abused people suffer from disorders with a "relationship aspect to it (e.g. substance abuse/ co-dependence, borderline personality disorder etc). A major difficulty would seem to involve teasing out sociological factors from the psychological results of abuse.

GROUP THERAPY WITH ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE

A REVIEW

The research on using groups as a therapeutic tool with sexually abused people is quite sparse. This is despite the wide spread use of such groups (eg Yalom, 1975; Gordy, 1983; Berliner & Ernst, 1984; Gagliano, 1987). Peake (1987) argues that the group format allows the victims to develop a deep sense of trust and support. These studies describe a format which is very similar, namely six to ten sessions all beginning with an initial phase to form the group. Friedrich, Berliner, Urquiza, and Beilke (1988) say this is the most important and crucial stage as the acceptance of others will signify how well the group works. This is followed by the middle phase which typically deals with different issues each session. This may be structured with greater teaching input from the therapist, or it may be less formal with the group members deciding what they wish to work on. This depends on the therapists competence and the group maturity.

One common feature of these groups is they are more discussion/therapy/support groups as opposed to straight therapy groups. From the information provided, a lot of healing and changing comes from the

group members sharing their experiences of abuse. This allows group members to identify with each other and realise they are not alone (Gordy, 1983; Singer, 1988; Gagliano, 1987).

Some of the issues which were dealt with in the group setting in were vulnerability, bouts of depression, neediness, shame, aggressiveness, guilt and for boys especially sexual aggressiveness, masculinity, and homophobia (Freidrich et al. 1988). Singer (1988) reported low self esteem, substance abuse, powerlessness and control, self-destructive behaviour, difficulties in interpersonal relationships, trust, intimacy and sexually related issues among the men in his group. Many of the men viewed themselves as "damaged goods". Draws and Bridle (1989) report themes in their groups of sexuality identity, power, trust, taking responsibility and understanding relationships and dysfunctional roles. Gordy (1983) and Gagliano (1987) report similar findings.

Freidrich *et. al.* (1988) worked with abused boys and talks of two main issues specific to abused boys. The first, because many of the boys were engaged in homosexual abuse, group treatment may aggravate their inhibitions about discussing this. Here developing group cohesion and trust is particularly important. The second issue is the development of later sexual offending. Freidrich *et al.* (1988) believe groups may have an important role in stopping this from occurring. One of the key areas surrounding the development of such offending is the emotional and social immaturity of the boys. Learning to

function in peer relationships may impede the development of later sexual offending. The final phase is the termination phase where the group ends and the members decide where they need to go. The ending is done in the group setting, preferably, or in a one to one with the therapist.

The above authors (Freidrich *et. al.*, 1988; Singer, 1988; Gordy, 1983) recommend several treatment options which they have found useful. These revolve around reversing negative beliefs and experiences about themselves and include letter writing, validation of peoples experiences, and externalisation of inner turmoil through roleplays and talking (Singer 1988, Wilson & Hutton 1992). While Gordy (1983) advocates examination of messages each survivor received as a child within the group setting, so the adult can make choices about how they live. They also recommend individual therapy as well as group work. Two reasons are given for this: 1). It gives people somewhere else to deal with issues if they feel uncomfortable in the group; and 2). Many of these groups are designed for people entering their healing from abuse and as such the group may not wish to explore things too deeply while individual members may want/need to. Other authors have used other therapeutic techniques as presented below. Apolinsky & Wilcoxon (1991) advocate an eclectic approach to therapy saying this allows them to adapt more readily to the group needs. Hypnotherapy is used in the group setting by Gilligan & Kennedy (1989). They report this improves the victims ability to

communicate effectively, this is accompanied by an increase in self-esteem. Kelly-Garnett (1989) found the use of symbols important to group members describe their pasts, present and future.

However, while the strength of these studies lies in their description of the group as a therapeutic tool and the issues involved in running such groups, they fail to show if and why groups are useful and which type of groups work best. In short, these studies are more a clinical description of what these authors are doing with their groups and some useful treatment ideas rather than an investigation of groups as an effective therapeutic tool. This makes their usefulness very limited. Clarkin, Marzial and MunroÄBlum (1991) suggest very little research, other than clinical observation, has been done using groups and no one to their knowledge has evaluated combining groups and individual treatment. Yet this is the most common form of treatment within the therapeutic community.

One study looks solely at whether groups work and which type of group works best. Alexander, Neimeyer, Follette, Moore, and Harter (1989) compared four ten-week interpersonal transaction (IT) groups (where all possible group dyad combinations share their view of a particular topic), four ten-week process groups (where the therapist allows the group to decide what to do and facilitates the process so this happens), and a wait list group Subjects, all adult women, were evaluated pretreatment, post treatment and at six month follow up on

measures of social adjustment (Social Adjustment Scale), depression (Beck Depression Inventory), fearfulness (Modified Fear Scale) and general distress (Symptom Checklist Revised SCL-90-R). They found that both groups showed significant improvements over the wait list group which showed a deterioration. There were no major differences between the two groups (this is consistent with other research on psychotherapy groups), although the process group showed better overall social adjustment ratings due to the nature of the group. Follette, Follette, and Alexander (1991), in a follow up study that used the same format as Alexander et al (1989), looked at the individual predictors that determine successful group treatment. They looked at demographic variables, sexual abuse history, characteristics of the family of origin, and initial levels of depression and distress. Employing a hierarchical regression analysis using post treatment social adjustment scale score as the dependent variable to determine the impact of these variables found five variables associated with lower pretreatment adjustment were found. These were, those with less education, more psychological distress, (as measured on the SCL-90-R), depression, (as measured by the BDI), and lower marital satisfaction. There was also a small, but significant, relationship which indicated a tendency for shorter periods of abuse to be associated with poorer adjustment. The authors also looked at those variables predicting response to treatment. They found less education predictive of poorer treatment response. Subjects who experienced oral-genital abuse or intercourse did less well than

those who were subjected to fondling without penetration. Abuse duration was not associated with response to treatment. Prior levels of adjustment also reflected on post-therapy adjustment with higher levels of distress and depression associated with poorer treatment response. Single subjects had better treatment responses than married subjects, although levels of marriage satisfaction had no effect on treatment outcome. Finally a trend developed between previous therapy experience and the type of treatment the subject responded to. Subjects with previous experience responding better to the process group. Cahill, Llewelyn and Pearson (1991) in their review of the literature on treatment strategies for sexual abuse describe three different group formats: the short-term time-limited approach, the open ended group, and the self-help group. The time limited approach is by far the most common format and is claimed to have several advantages by several authors (Alexander & Follette 1987). Herman & Schatzow (1984, cited in Cahill et al 1991) say this format facilitates group bonding and provides a clear structure for dealing with painful feelings and memories. Goodman & Nowack-Scibelli (1985, cited in Cahill et al 1991) say it keeps the focus on the incest and establishes very clear and firm boundaries. This is very important as most incestuous families deny they have a problem and incest of its very nature crosses boundaries. The strength needed to deal with incest is also highlighted in these groups where it can be used to counteract feelings of powerlessness. The main goal of these groups is to allow people to share with

each other thus reducing their feelings of being isolated. As well as providing a structured, safe format for group members to explore various topics, and to disclose their stories. These just mentioned factors, the authors claim, is the key to therapeutic success. This is because as the abuse is recounted the emotions associated with the abuse are able to surface allowing them to be made available for healing. However, others feel the main role of the therapist is to facilitate so the feelings can emerge. Once the feelings have emerged the role of the therapist and group becomes one of supporting and validating the client. Alexander & Follette (1987) describe a group process where personal constructs are examined and changed in discussion.

Blake White & Kline (1985, cited in Cahill et al 1991) describe a long term open-ended group which they claim has several advantages. There is more time for in depth exploration of issues; having members at different stages allows for new members to get an idea of the stages and to expect a positive outcome; and older members can share their experiences with newer members, facilitating the newer members process of healing. Newer members are said to just `fit in' and not interrupt the group process or the developmental sequence of older members.

Self help groups have not had a lot of research carried out on them as yet mainly because of access problems to such groups, yet their use is increasing and many may offer a better service than professionals offer (Herman & Hirschman 1981).

Groups are shown to be powerful therapeutic tools. The group environment has obvious benefits: it can help many people at once; it can provide a safe environment to share and explore feelings; and provide fast effective therapy. However more research is needed in area's like what combination of factors makes groups effective, and what about combining group and individual work.

METHODOLOGY

General points.

Haig (1993) argues that methodology is the general study of methods rather than being concerned with any one method or technique. He says methods are a means of achieving a goal, in this case the advancement of our understanding of the world. Methodology is seen as descriptive, critical, and advisory. It recommends relevant methods and explains how they can reach specific goals.

This thesis is based around a data generative approach. This is different to the normal hypothetico-deductive method of empirical science where causal relationships are tested. The standard empirical method works from a cause and effect regime where reality is a world of objectively defined facts. This approach has the scientist experimentally controlling subsets of variables in order to test some facet of prior theory, and where the prior theory directs the process of collection, analysis and interpretation of the data. Quantification - The sum of standardization, measurement and number - is crucial to the empirical approach because it allows the concepts behind the theory and the hypothesis to be observed and measured. These findings are to be replicable and generalizable so the theory proves to have predictive power, and thus describes some law or regularity of "nature".

The data generative method has as its focus description with explanation coming

later with theory building. This enables the full richness of some area of study to be researched. We each see the world through our eyes and with our experiences; this is the reality this approach endeavours to appreciate, the importance of viewing the meaning of experience and behaviour in its context and in its full complexity. This allows scientific inquiry to generate working hypotheses, rather than immutable empirical facts, and emphasises the emergence of concepts from data rather than the imposition of concepts based on *apriori* theory.

Using this approach means that inappropriate meaning will not be attached to observed phenomenon. Meanings may be context driven and are variable or by neglecting the uniqueness of each persons experience inappropriate meaning may be attached. Finally imposing an "objective" system of meaning on what is essentially an internally structured subjective experience may result in inappropriate meaning.

Further, this approach allows for the scientist to be sensitive to people and their experiences. Many feminist researchers, for example, are using this method and claim it is empowering of women in their efforts to change. It enables the research to be sensitive to womens experiences by seeing these experiences in their own terms (e.g. Duelli Klein, 1983; Griffin, 1986). Further, empirical science has forced a split between researcher and the subject of research (Keller, 1983). Therefore there is a need for the researcher to re-connect to the subject.(Glennon, 1983)

Henwood and Pidgeon (1992) suggest the use of both qualitative and empirical science as a way of strengthening research. Latour (1987) says that "quantitification is but one manifestation of the common practice of deriving coherent, mobile, and combinable inscriptions in science". This shows that these two approaches, although seemingly different, are but different forms of the same practice, namely re-representation in science. With this in mind it would seem possible that the use of both approaches is both possible and desirable.

This thesis, however, uses only the qualitative approach, and involves describing the effects of sexual abuse on five men, individually and in a group. The emphasis in this thesis is on describing these effects from the eyes of the men, and on describing the experiences they have been left with. This is where the value of this research lies.

This thesis is not concerned with generating a major explanatory theory on sexual abuse, mainly because it is beyond the scope of the study undertaken. Further, sexual abuse is itself a sub-set of other factors such as violence, oppression and sexuality, and the data gained from the men represent only a small portion of the total data available on sexual abuse. However the data does generate some findings, in the form of general conclusions, and this marks the beginnings of a theory.

This thesis also has empowerment as an aim of the research. This is

accomplished on several levels. Firstly in the process of having the men as research participants they gain awareness of their own process. Secondly, this thesis helps all men who have suffered sexual abuse by exposing this issue bringing about awareness. Finally, by adding to the general knowledge base of all abused people (sexually, physically and emotionally) everywhere.

The Case Studies

The case studies were autobiographical, in nature, in that they tell the mens own stories and not what I, as the researcher, thought they said. Case studies are commonly used in qualitative research as they allow for the full expression of the participants' responses.

De Waele and Harre (1979) point out the use of extensive (empiricism) versus intensive (qualitative) designs. They say intension varies inversely with extension. Namely, the more proper ties that are used in the definition of a typical member of a class the fewer individuals are likely to be found exhibiting those properties, resulting in a smaller class extension. They recommend the use of both designs.

Sayer (1984) maintains "extensive" research is primarily concerned with mapping common patterns and properties of a population in a descriptive sense, whether or not they are related in a causal way. Thus, if one uses this approach for causal

analysis, which focuses on taxanomic groups whose members share similar attributes but which need not connect to each other, one gets casual relationships based on statistical association of formal properties. However, the "intensive" design bases its causal analysis on observable concrete connections between actual people and actual properties.

Stoecker (1991) echos Sayer's comments by saying a statistical association may imply many different answers. Only through careful sensitive research of specific instances that actually show the historical causal process can we hope see the which theoretical perspective best suits the data. The case study, then, can better analyze causation than quantitative cross-sectional research. She goes on to say the strength of case studies is in their ability to explain the idiosyncrasies which make up the "unexplained variance". And that if we start with a comparative focus we may produce a design which does not allow for the idiosyncrasies and reduce the cases to a few variables to compare, thus loosing the purpose of the case study.

When developing a case study Stoecker (1991) argues the need to consider four issues in order to check for external validity: the role of theory; the historical perspective; the multimethodolgical approach; and the role of the researcher.

In the case of this thesis, theory will not be an immediate outcome of the research. Instead this thesis is a preliminary study aimed more at describing than

theory construction. Theory will be a much longer term outcome to which this thesis may contribute. The historical perspective is important as it puts limits on what the case study researches. In this case two areas are considered now and the time of abuse. This allows for the present day effects to be seen in an historical element thus allowing for developmental aspects to be considered. The use of multiple methods is not appropriate given that the study is concerned with the use of data generative methods in order to describe the effects of abuse. Finally, the role of the researcher is very important in this study because it effects the outcome of the research. How does the researcher bias the results, and how can the researcher enhance the outcome? The feminist literature (e.g., Glennon 1983; Oakley, 1981; Stanley & Wise, 1983) cites this as a most important factor for this type of research. Instead of the researcher being objective and aloof, the researcher needs to gain understanding and insight into how the participants experience their lives. That is the researcher need to be a participant observer. Luxton (1980) and Willis (1977), both cited in Stoeker (1991), went back to their participants to ensure the information was correct and in many cases the information needed updating and correcting. In the case studies in this thesis this action of involving the participants in the research process occurred, with the case studies receiving many up-dates before being presented.

The case study seems the most effective tool available in order to study the nature of the topic presented in this thesis. It offers a chance for viewing the experience of abuse through the eyes of the abused, an understanding which traditional empirical methods cannot provide.

The Group

Here again the participant-observer model was used. I, as the researcher, became part of the group. The group was part of the research process giving feedback on, and updating each session. Here the group can be seen as a kind of case study but with the focus of the research being on the "here and now" examining how these men participate in a group. This is done by describing group process. This research is about this group of men only and may have no further application, although it may offer insight into how sexually abused men function in groups and other relationships. The group process really offers insight into how this group of men operated in this group.

METHOD

Demographics.

Five men from Christchurch were involved in this study. Their ages ranged from 30 - 50 years. The men were from the lower socio-economic bracket. They were all poor achievers at school with only Mr G achieving University Entrance. Four of the men were working; three were supervisor/foremen, Mr M was the manager of the firm he worked in. Mr G was unemployed and completing his Electronics Technician's Certificate. Four of the men were either married or in a defacto relationship. Mr G was single and wished to remain so for the foreseeable future.

Referral

All the men were referred from a group that was being run for male victims of sexual abuse in Christchurch. This was done on a voluntary basis and the men were invited to be involved in the whole research project or one of its two parts.

Case Study

This thesis involved two parts; a case study and a therapy group. For the case study I interviewed the participants using an open-ended interview schedule (Appendix 1). I asked the men to tell me their experiences of abuse and used the

schedule only to make sure I had covered all the areas I wished to ask, or, to prompt the men as needed. I recorded their answers on the schedule but only after consulting with them on what I wished to record. The men reviewed the schedule after the interview to see if this was an accurate statement of what they had said. Once the interview information had been compiled it was sent to the men asking for their comments. This was reviewed by the men and myself several times, until we were both satisfied with the document which is presented in this thesis.

The interview was divided into nine major areas: demographics; a description of the abuse; consequences of the abuse - immediately following abuse and now; family dynamics; how did you know you were abused; consequences of disclosure; how did you survive; and the process of recovery.

Demographics

The first section of the schedule dealt with demographics such as age, marital status, education, etc.

Description of abuse

The next section of the schedule asked for a description of the abuse that occurred. The questions looked at who knew and who was involved, what support

was available, what type of abuse occurred, and when it occurred.

Symptoms and consequences

The third section of the schedule is really a checklist regarding symptoms and consequences of abuse. This checklist is not exhaustive and was used as a guide to help cue the men and myself as to the possible effects of abuse. The checklist was used twice, the first time to find out consequences at the time of the abuse and the second time to find out the present day effects of the abuse. This lends a retrospective bias to the checklist. However the focus of this study is to understand the current effects of abuse in the men's lives and this includes the memories of their abuse which are subject to bias over time.

The checklist is divided into two parts: emotional consequences and psychological consequences. The emotional section was derived mainly from clinical experience and partly from Lew (1988) and Bass (1988). The psychological section was further divided into eight parts. These were drive, control, fear/phobias, sexuality, addictions, contact, abuse, and any other.

1. Drive

I used this essentially as a lay term with the men, asking them to describe their levels of motivation. I asked about their general levels of motivation, any problems they had encountered and about their ability to concentrate when doing any task they may be involved in. I asked about procrastination as I suspected that motivation levels and self esteem would be related. Where self esteem was low I imagined motivation levels would also be affected, being either too high (workaholic) or too low (procrastinator). I then asked the men to rate how seriously motivation problems had affected them in their lives.

2. Control

This refers to any pathological need the men had to control themselves or others. This may show as perfectionism to helplessness. It includes any need to appear not in control.

3. Fear/phobias

The next section on the checklist looks at the development, if at all, of fears and phobias in the men's lives. Nightmares that may have occurred as a result of the abuse are included here. Their association with fears is loose and is based around

Post Traumatic Stress Disorder criteria.

4. Sexuality

This is concerned with how the men's sexual identities, including any dysfunction, developed as a result of abuse and whether or not they sexualized their relationships. Also if they themselves became perpetrators.

5. Addictions

Here checks are made to see if these men developed addictive behaviours, including drug/alcohol use, as a means of coping with their abuse.

6. Contact

This a Gestalt term which refers to the expression of intimacy. It involves asking some practical questions about intimacy in the mens lives as a way to discover how well these men relate with others.

7. Abuse

This looks at self-abuse, from relationships to suicide. This was to see if and how much the men used abuse as a coping tool.

8. Other

The final category covers a range of other consequences such as bed wetting, regression, criminal behaviour, and feelings of leaving ones body (Lew 1988).

Family dynamics

A lot of research has shown that abuse occurs in the family (e.g. Pierce 1987, Faller 1989b). This research has also shown these families were dysfunctional and that victim characteristics are common among other members of these families. (Garbarino, 1975; Western, 1985). For this reason I have borrowed the model used for dysfunctional families as proposed by the Adult Children literature especially Anne Wilson-Schaef and Claudia Black (among others) as a means of describing family process. This includes four roles that children in dysfunctional families tend to take on. These are Hero, Rebel, Lost child, and Mascot. For a fuller description of these roles please read Appendix 3. Briefly these roles are:

The hero is usually the first child in the family. This child is forced to be responsible for the other children in the family. In extreme cases this child has to become the adult/parent of the family. As a result this child is usually very responsible in everything they do. This may become pathological as the need for

control and perfection develop with the need to be responsible. The hero is more likely to be a high achiever and will appear very grown up for his/her age.

The Rebel will often be the second child in a family and will be the opposite to the hero in many ways. In extreme cases this child will get into trouble a lot, is a low achiever, and is irresponsible. As a result this child sticks out as the "problem child" in the family. Hence this role is also known as the Scapegoat.

The Lost Child is usually the third child in the family. This is the most common category for the men in this study. The Lost Child will often be withdrawn and lives in a fantasy world. This child has few social skills and will retreat from life and friendships.

The Mascot is the child who tries to make the family feel better by taking the heat out of situations. The Mascot achieves this by being a clown or doing something which distracts the family such as scalding themselves with hot water.

The next section of family dynamics: "Roles in the Family" is another approach to dysfunctional families borrowed from Transactional Analysis (TA today). Again, these are used to give the men a framework to describe their family. These roles are useful as they offer insight into how family members interact with each other. The roles relate to the Child, Adult, and Parent ego states as follows: Parent -

Persecutor; Adult - Rescuer; Child - Victim. The roles used in this thesis are obviously dysfunctions of the normal "three ego states".

The third section focuses on the abusers, including their relationship to the abused men.

The final section under family dynamics looks at any major family stressors that may have contributed to family disorder.

I did not wish to delve deeply into the relationship of families to abuse as I believe this is already well documented (e.g. Pierce 1987).

How did you know if you were abused?

This section looks at how people knew they were abused. Questions include "Did you suddenly remember the abuse or have you always remembered the abuse?" " What events led to your disclosing your abuse?" "To whom did you choose to disclose and why?"

Consequences of disclosure

This section deals with a wide variety of consequences ranging from the personal through to work, relationships and anything else that may have emerged as a result of disclosure.

How did you survive?

The second to last section looks at how the person survived the abuse at the time of the abuse and after the abuse had stopped and in particular what coping mechanism or strategy the person used in this process. Several options are listed. These are the more common strategies as reported in Lew (1988).

Process of recovery

The last section is really a self assessment of where the men think they are at in the process of their recovery. I adopted this category from the book Courage To Heal by Ellen Bass and Lauria Davis.

The information gained from the interviews is presented in the Case Studies. The format is basically the same except for the last four items on the schedule. These have changed to:

1). *Disclosure* - the events surrounding disclosure of abuse and consequences of disclosing.

2). *Coping with Abuse* - finding out how the child coped with the abuse.

3). *Current Coping* - examining how the adult of today is coping with the abuse.

4). *My Assessment* - my assessment of these men before they go into the group and

what issues they may need to work on

The Group

The second part of the thesis was a short focused therapy group. The group was based on the Gestalt model. This was decided by the group in the first session.

Gestalt is a process-oriented therapy whereby the figure or foreground is followed (see appendix 2). This may or may not have anything to do with the content of what the person is saying. When a person is following their foregrounds they are said to be flowing with their awareness of their foregrounds. With certain foregrounds comes an imbalance in the person's state of being and thus a need to return to this state of homoeostasis exists. This is called the Gestalt Cycle. When a person cannot follow their foregrounds the Gestalt is not complete. This leaves the person with unfinished business. The ways in which the person stops his or herself from this flow of awareness are called the resistances. There are five types of resistances; projection, confluence, retroflection, deflection, and introjection. Gestalt works the resistances in such a way as to reduce them, allowing the person to flow with their process rather than get caught up in their resistances. The essence of Gestalt can easily be translated to the group situation where the group is seen as its

own entity, as well as a collection of individuals. There are of course differences, but these are beyond the scope of this section. In fact, working in groups is often easier than working with people individually as there is far more energy for growth and change present in the group.

A description of the group process was recorded at the end of each session. This was done easily using the Gestalt theory and therapy skills to observe the group process. Each session's themes were recorded. This was the framework which was fleshed out by the pieces of work which occurred in each session. This gave an outline of group process which was expanded on by including the interactions that took place between group members. This document was taken to supervision the next morning with Associate Faculty of the Gestalt Institute of New Zealand for the therapeutic aspects of this work. The following week the document was taken back to the group and the men were invited to make any changes they wished and we arrived at a statement of process for the last week. This is what has been recorded in the results section in this thesis under The Group.

Follow Up

Follow up started on the last session of the group and was informal. Each man was asked what he had gained from the experience and also what he still needed to do, what he liked and didn't like about the group. I recorded each answer on paper, verbatim. For those men who did not make the group I had an individual session shortly after the final group night This was followed by a telephone call a month later where the statement each man had made on the last group night was read back to them. I asked if anything had changed or if they wanted to add more. I then read back to them their up-dated statement and, also, gave them my assessment, if they so chose. This information is presented as - FOLLOW UP: The Men after the Group in the results section.

RESULTS AND COMMENTARY

Case Study

Case Study No.1.

Demographics

Mr G is 30 and single. He is currently unemployed but is studying for an electronics technician certificate and ultimately the New Zealand Certificate of Engineering (N.Z.C.E).

His health is good although he is an asthmatic, which he has been since two years of age.

Abuse

Mr G was abused, when he was 13 - 15 years of age, by his uncle who slept in the same room. This happened every night when his uncle came home from work, except when his uncle worked on night shift, and so occurred three out of every four weeks. Mr G said he would forget the abuse happened during the day until his uncle's car came up the driveway. This was partly because Mr G thought this happened to everyone, and so abuse wasn't abnormal or something to fear. However Mr G hated being abused by his uncle. No one else knew of the abuse at this time. The types of abuse ranged from anal intercourse to fondling etc, and would occur

when everyone was asleep. Mr G's uncle would come into his bed and start by fondling him and this would lead to masturbation and sometimes anal intercourse.

Consequences of Abuse

Immediate reactions to the abuse

At the time of the abuse Mr G remembered that he was withdrawn, depressed and had very low self-esteem. Mr G believed that if people truly knew him they would reject him. He found it hard to talk to, trust and receive comfort from others. He also found it hard to express his vulnerability and was very fearful of intimate contact, partly because his sexual orientation was very unclear as a result of the abuse. His ability to concentrate plummeted. At the time of his abuse he wanted to kill his abuser. All these issues have plagued him throughout his life.

Current reactions to the abuse

Mr G still finds he gets depressed and withdrawn, and finds any contact with people hard. However, this is not as bad as at the time of the abuse. Mr G found that his emotions today remain fixated at the time of the abuse, and so doubts any feelings he has. He often feels that different parts of him are in different worlds (the adult world and the child-abused world) and so he has problems understanding

what is real at times.

He feels unloved, unsupported, guilty and shameful about his abuse. He often wishes he were someone else. However, he does not generally feel helpless.

He has found it hard to concentrate on any task since the time of abuse. One way he has found to deal with this is to control himself rigidly; he gets very frustrated and feels helpless when he can't do this.

Mr G is 99% sure of his sexual orientation now, but has preferred to remain celibate because of his fear of intimacy. He has not, however, confused sex, love and abuse but recognises sex, love and intimacy are all necessary for a healthy relationship. He has found masturbation a good coping mechanism.

He is aware of some co-dependent attributes where he tends to block himself off from his relationships so he does not have to be too intimate. Despite this he feels jealous of other people's relationships and wishes he could have one too. He found that he couldn't say `no', that he always had to please others. He believed, and to some extent still believes, "That if they truly know me they will reject me". He still finds it hard to receive any comfort or nurturing from others. He looks on this suspiciously and asks "What do they want from me?". He used to steal compulsively but now, despite still having the compulsion, he does not.

He did and still does, to some extent, blame himself for his abuse and often

abuses himself in small ways such as failing to take asthma medication or neglecting himself. He has, in the past, made suicidal gestures and has wanted to die but no longer feels this way.

Family Dynamics

Mr G's family were dysfunctional. He took on the role of a `Lost Child' and would often escape in `Sci-fi'. Here Mr G mirrored his father who was also a `lost child' and was thus emotionally absent from his family. Mr G and his mother often took victim roles, within the family system. His eldest sister was the persecutor and his middle sister was the rescuer, from whom he received most of his parenting.

Mr G's parents were told of the abuse but offered him no support and instead denied the abuse had happened. His parents separated when he was 8 years old, his father left but made little attempt to contact Mr G. Mr G's uncle (the abuser) became the father figure in Mr G's life. His mother got in a sexually abusive relationship after the separation and so abandoned Mr G, leaving him to his own devices for most of his childhood.

Disclosure

Mr G had always remembered his abuse but, although he had been to see a few

counsellors, he hadn't realized how much of his life had been affected until he was 29. At that time he failed what should have been an easy exam.

At 22 he sought help. The relationship he was in didn't work out. While he slowly realized this was because of abuse issues, he still did not fully understand the extent of this. He still blamed himself for the abuse and, although he sought help, he got no support and withdrew.

At 24 - 25 he saw 2 different counsellors. He maintained they were unhelpful. In fact, he believed they had a detrimental effect on his `recovery'. He then discovered the `Courage to Heal' book by Ellen Bass which Mr G said was `him', despite being written for women. Mr G then found a good counsellor who helped him when he was 29. He is still seeing him.

As a result of his first disclosure, his self-image plummeted and became extremely low. His emotional life became very fragmented but stabilized over the next 10 years, to the extent where he was a victim/survivour but not really `alive', still very caught up with the abuse issues. His relationship to his family became increasingly worse and he was `tossed off' to his first bad counsellor. However he learnt to cope socially. His work suffered increasingly. He was just surviving and no more.

Coping with the Abuse

As a child he coped with his abuse by forgetting each incident during the day but remembering it in the evening when the abuser arrived at home. He used a lot of humour to deflect the pain. He made fun of himself so he then felt worthless and so didn't need to deal with the pain. He also escaped a lot into `Sci fi'.

Current Coping with the Abuse

He is at the moment learning how to trust himself and nurture the inner hurt child. He is aware of grieving and that he is angry but is not yet willing to look at this. He needs to learn how to build intimacy with others so he can form relationships. Other steps he will need to take will be to forgive himself and to stop abusing himself. He will have to learn to say "NO!" and build his self-esteem.

My Assessment

He is interested in joining the group but is finding it to hard to be intimate with others and share his emotions. This will be what he needs to do next if he is to heal and start a relationship.

Case Study No.2.

Demographics

Mr D is 32, a chef and in a defacto relationship. He has 2 children from a previous relationship, a six year old and a three year old. He is the third of five children and enjoys motorcycles, cars, fishing and his partner.

He has school certificate. and left half way through the 6th form. His health is generally good but he has the start of an ulcer, which is stress related.

Abuse

Mr D's abuse occurred for about three years from around 12 to 13 until 15 or 16. The abuser was an officer in the sea cadets. Mr D was one of several cadets the officer abused. Many generations of cadets had been abused by this man. The other non-abused cadets were aware of the abuse too, but no support was offered to Mr D or any of the others.

The abuser eventually got caught and had to resign. Recently Mr D filed charges against his abuser for sexual abuse.

The abuse was limited to oral sex, masturbation and fondling, and occurred on three occasions. The officer invited him into his quarters on each occasion and pulled his pants down, with no warning, and started to fondle. On the third occasion

this included oral sex.

Consequences of Abuse

Immediate reactions to the abuse

Mr D was withdrawn and depressed until a few months ago. When the abuse occurred Mr D found it hard to trust, talk and be intimate with other people, and his self-esteem was very low. Mr D had trouble saying "no", making contact with and receiving nurturing from people. He was secretive about his abuse and believed "if they really know me they will reject me". He had also thought about suicide.

He found that when he wanted to cry and be vulnerable he would get overwhelmed and then simply `close down'. In this way he avoided showing any emotion. He found his emotions were fixated at the abusive incidents and that he had a large amount of grief which he did not want to deal with. Instead, he would problem solve without any emotional content and could thus remain distant from his feelings. He found that expressing emotion was hard because he had trouble accessing a "normal" emotion, only accessing an overwhelming feeling that he instantly suppressed. This often left him feeling confused.

He felt loved but unsupported by his family, because he didn't talk about his abuse. He felt guilty and ashamed of his abuse and on the outside of life - a bit

different. He thought he might be gay.

He also had a great need to be in control of himself and others - either directly by pretending to be helpless, or by self-pity. Despite this he found that up until a few months ago he had trouble with procrastination, but once on task he has no trouble doing things.

He found that cigarettes or alcohol became a problem, but did not become an addiction, more a `social lubricant'.Mr D tends to eat heavily when he is depressed.

He has had sleeping problems and urinary complaints which have since been resolved.

Current reactions to the abuse

Today most of these issues are resolved or in the case of having, owning and expressing feelings, improving rapidly. Four years ago he entered therapy but he says he made a breakthrough only a few months ago. Issues around his abuse have only really started to change since this time, especially around getting his needs met and being intimate with others. In times of stress he can still get attention through self pity. He has no desire to commit suicide and has not since shortly after beginning therapy. At the time of abuse Mr D thought he might be gay, but now seems satisfied that he is heterosexual.

Family Dynamics

Mr D's family was dysfunctional. Mr D was a `lost child' in a fantasy world, within his family. His parents were very strict, so much so that Mr D felt squashed (this is also reflected in his control issues - he needs to be in control or else he will be squashed). The children were "seen and not heard", not close but not distant. Mr D said there was a strong bond amongst siblings. His parents kept things well hidden from their children - the father was often suicidal (another form of control?) and the mother just "stressed out" and upset. The children were aware of the tension between them.

When Mr D told the family of the abuse, recently, they were supportive but his father said he should just get on with life. They didn't blame him for the abuse.

The abuser was a distant friend of Mr D's mother; he was alcoholic and still lived with his own mother. When Mr D's mother confronted the abuser he lied about the abuse. But Mr D confronted him the next day. He just said he couldn't admit to it. Since then Mr D has filed charges.

Disclosure

Although Mr D remembered the incidents he didn't label it abuse because he didn't know what abuse was. He first realised he was abused when he was in

counselling with relationship difficulties, and his partner talked about her own sexual abuse. He first disclosed to his counsellor, to find out if this stuff was really abuse. He has since left the relationship because he couldn't say "no" to his partner.

His self image improved with his disclosure. He felt like he was going places. He began to realise how his abuse was a 'reflection' of his sick family system. This was however a very traumatic time with lots of pain and sadness. His family supported him through this time and accepted him for who he was. Also he left his partner which was both good and bad. He says his work was unaffected.

Coping with the Abuse

Mr D coped with the abuse by minimising it and trying to forget it. He minimised by saying it wasn't abuse and it only happened a few times. However he couldn't forget and had to face up to his abuse with the breakdown of his marriage.

Current Coping with the Abuse

He still minimises the abuse but he is aware he does this. Instead he will take any difficulties he is having to therapy and deal with them there. He is finding many of his own answers there.

My Assessment

Of all the men I believe Mr D has resolved the most concerning his abuse. Some issues I believe he needs to deal with are his anger and sadness towards his family, for not supporting him, also his abuser, for the pain he suffered. He is at a point of needing to get angry with the abuser and maybe confronting him some more. In this way he can learn to express his emotions and lift some of the blame he has been carrying around. Mr D also needs to resolve his relationship with his ex-wife. I believe he is still very angry with her. In this case study I found he avoided talking about her but was open to other sorts of questions.

Case Study No.3.

Demographics

Mr P is 50, separated, has three children and works as an engineer. He left school in the Canadian equivalent of 3rd form. He holds a 1st class engine drivers certificate which took seven years to complete. He comes from a poor background and was the 10th of 14 children. He enjoys beach buggying and dancing. He is in good health although suffers a non-serious heart palpitation.

Abuse

His abuse occurred nightly over an eight month period. Mr P was 12 at the time and was abused by his elder brother. The abuse involved masturbation. Mr P was unable to stop the incidents, "he just kept going" and no one else knew the abuse was happening.

Consequences of Abuse

Immediate reactions to the abuse

Mr P remembers he was withdrawn, depressed, had low self esteem and found it hard to trust and talk with others from the time of the abuse to the present. He has a fear of intimacy. He sees two reasons for this. The first is the sexual abuse, the other is what he calls 'puppy love' which didn't work out and devastated him. He said being abused affirmed what he already suspected, namely "I am no good". He has found it hard to receive nurturing or comfort since the abuse. He felt unloved, unsupported, guilty, and ashamed of the abuse. He has always blamed himself for the abuse although this is lessening.

Mr P buried his emotions at the time of the abuse and so found it hard to experience or express any emotions. This has changed very little but his emotions are beginning to emerge. At the time of abuse he wished he was big and strong so

he could have killed the abuser.

At that time he procrastinated when it came to working. He had a need to control others in case they hurt him too.

He initially thought he might be gay. This was reinforced as he grew because he did not orgasm during intercourse with a woman. He gets a "big hurt" - this is accompanied by feelings of sadness. However, Mr P could masturbate normally but he also had a lot of urinary problems. He links these problems to the abuse because when he got checked by a doctor, he was told that physically there was nothing wrong.

Current reactions to the abuse

Although his self esteem has increased, many of the issues outlined above are still current and alive. He still has sexual problems but no longer believes he is gay. He is now very angry with gay men as a result of being abused.

He still has trouble with being intimate with other people, as he now links abuse with love, but only recently did he realise how he found it hard to "connect" with others, or believe that people like him. He is starting to say `no' to people as he has started dealing with his abuse.

Recently he has been experiencing flashbacks and having suicidal ideation. Mr

P no longer wishes he was big and strong. Now he just wishes he was someone else. He now has a need to have control of himself as he is finding gambling a concern. Now Mr P has a compulsive need to wash his clothing.

Family Dynamics

Mr P's family was dysfunctional. They had many stressors that contributed to this, including the size of the family and poverty, an elder sister being raped and a younger brother dying from cancer.

He was a `lost child', and as a result of living in a fantasy world MrP would often be the family scapegoat. Interestingly Mr P's family also disliked the brother who abused him. He has shown repentant behaviour, towards Mr P - but he also manages to put Mr P down at the same time by calling him dumb and weak. This continues the mental anguish as he feels re-abused.

Disclosure

Mr P first realised he was abused while in counselling for his marriage breakup. Although he always remembered the events he didn't label it as abuse. He had labelled the event a "dysfunction". He went to counselling in a last ditch effort to save the marriage as he had distanced himself from his family. He first disclosed

to his wife.

He viewed himself at the time of disclosure as unclean - "I shouldn't have let that (the abuse) happen". He lost his wife and children and so was alone. They just shrugged off the abuse, offering no support. He found he forgot to do things at work also.

Coping with the Abuse

He coped with the abuse by denying it had happened by labelling it "a dysfunction" rather than abuse. He did accept something had happened and that it hurt, so much so that he wished he could have screamed to get help - but didn't. He tried to bury his memories of his "dysfunction" so they didn't hurt him everyday. He was very backward in social skills but put it down to "just shyness". He also tried to laugh it off and keep busy. He would drink to bury pain. He had a fantasy of being a healthy person.

Current Coping with the Abuse

For Mr. P, as with many others, healing started when he admitted that he was abused. He is still dealing with his emotional life such as sadness, grief etc, and is yet to disclose the abuse to his family of origin. He has not forgiven himself and

is beginning to look at his spirituality. He is starting to trust himself but this is hard because of his gambling.

My Assessment

Mr P needs to look at the addictive patterns in his life. I believe the gambling is only the tip of the iceberg. He also appears to be addicted to avoiding taking responsibility for himself. He is extremely angry but tries to, again, avoid responsibility for his anger. This comes out in all sorts of ways and belongs elsewhere, most likely towards his brother, the abuser and his family. I don't believe he has forgiven himself yet for the abuse. As a result I believe he can't trust others or let them near as he can't trust himself, yet. He needs to build self-esteem, and look at the abuse in the family system during his early years.

Case Study No.4.

Demographics

Mr M is 38, in a defacto relationship and has a stepson of 16 years and a son of two. He is the fourth of six children. Currently he is working as a manager but has trained horses and worked as a fisherman. He holds a heavy machinery licence. He enjoys horses, walking in the bush, motorcycles and gardening. He left school at 15. He suffers from bronchitis but is in good health. He is a drug addict in recovery and attends a regular 12 step meeting.

Abuse

His abuse occurred from five years old to 13 years of age. His main abuser was a friend of the family. Two of his brothers abused him as well. The main abuse occurred 3 to 4 times a week - but there was a break of 18 months, when his brothers abused him. One brother abused him once and the other six or seven times. This ended in violence. No-one else knew of the abuse and Mr M had no support.

The main abuser would masturbate Mr M and "played" around with him. His older brother tried to sodomize him, once, but didn't succeed and the other brother sodomized and masturbated him several times. Mr M didn't get an erection towards the end of the abuse. This stopped his brother from abusing him any further but not

his main abuser. Mr M confronted his main abuser at ages seven and 13 years. The abuse ended at 13.

Mr M didn't feel bad about his abuse at first but later realised that this wasn't normal. Mr M had a Catholic upbringing and was told to keep this a secret as "every sperm is sacred", he would go to hell if he told his parents and they would be very angry with him.

Consequences of the Abuse

Immediate reactions to the abuse

When the abuse occurred Mr M remembers he was withdrawn and depressed, had low self-esteem, found it hard to talk to, trust and be intimate with others. He couldn't receive comfort and nurturing and believed that "If they know me they will reject me". He could not say `no' to others and instead had to please them. Mr M is heterosexual and always has been clear on this but he has a strong fear of intimacy and women. Although he really wants someone, as soon as they "fall in love" he gets scared and disappears from the scene (literally).

Mr M found his emotions remained fixated with the abuse and they were very separate from him and hard to express. He felt helpless, vulnerable, unloved, unsupported and wished he was someone else. This was so strong he sometimes

lived in a dream world, not a psychotic state but close. He was very ashamed of and felt guilty about the abuse. Mr M also linked abuse with love and so hated himself. He tried to abuse himself with drugs, mainly opiates. This has been a life long struggle. He attempted suicide two years ago by an overdose. He has had to battle to maintain his recovery.

He was and is angry with the abusers - so much so that he planned to kill them and still wants revenge, today. He was too afraid to talk about his anger and is yet to release his anger.

Since the time of the abuse, Mr M has had a problem with procrastinating and concentrating on various tasks. Once on task, though, he is "into it".

He has eating and sleeping disturbances with recurrent nightmares of sexual abuse, of not getting away and being stuck. Sometimes he regresses to childlike behaviour. He would often move once his "history" caught up with him, although he has now decided to stay put and "not run from the problem".

Current reactions to the abuse

Many of these 'consequences' are still present for Mr M, but he is changing. He can express his vulnerability, he likes and wants to be himself, he no longer feels guilty about the abuse. He does feel angry and this is his primary emotional response to his abuse. He still finds it hard to be intimate and has developed a "showman" which can be a normal, happy-go-lucky man. Alternatively, he pretends to be helpless with others so he can get them to look after him. Inside he is scared of people still, and thinks they might want something from him. He is envious of his abusers lives today.

Family Dynamics

Mr M was the `rebel' and the `lost child' in his family - he would often fantasize a better life. His father was physically abusive toward his mother and also had a drinking problem. Mr M the fourth of six children was very much a victim in his family. Other family members would tend to persecute or rescue him. His family were not aware of the abuse. His abuser was a friend of the family. He worked for Mr M's family and is an alcoholic.

Disclosure

Mr M always remembered clearly his abuse and found that it was stressful and confusing. He felt guilty at always having carried it around and he eventually disclosed to his wife. She kept pestering to find out what was wrong and he told her. Mr M said it felt good to tell her.

After that his self-image improved and his emotional life became tumultuous. His family gathered around him at this time and offered him much needed support. Work wasn't affected by the disclosure but his drug problem, which he had hidden from his wife, became apparent. Generally this was a positive time.

Coping with the Abuse

Mr M found he survived by becoming paranoid and ultra sensitive to people. He used humour to deflect pain and often kept too busy to really be in the present moment. Addictions came out in later life. His fantasy life was very strong - he thought he was Peter Pan or some other comic strip character.

Also he enjoys the bush which he sees as having a spiritual nature for he finds peace in the bush.

Current Coping with the Abuse

Mr M is learning to nurture his `child' and trust himself. He is aware of his anger and has recently confronted his abuser. He is learning about and experiencing his spirituality. He is grieving his childhood but keeping this to himself. He says he is some way to forgiving himself for the abuse, because at first he enjoyed it. This is hard because now he is aware of the immense pain the abuse has left him with.

My Assessment

Mr M will need to look at trusting others, feeling safe so he doesn't feel his boundaries are invaded. He is yet to forgive himself for enjoying the abuse. He needs to release his emotions and find some way of expressing his anger towards all of his abusers. Finally, he needs to accept that his addiction is going to stay with him for all of his life and will remain a problem. The literature suggests that a high proportion of addicts have been abused and dealing with this is as important as dealing with the abuse (Stein *et al.* 1988). They are epiphenomena of wider dysfunction, which usually originated with the family (see appendix 4).

Case Study No.5.

Demographics

Mr B is 47. He has been adopted twice and is in his second marriage. He has one paternal child from his first marriage and one adopted child from his second. He works as a mechanic.

Abuse

Mr B's abuse occurred at three to four years of age by a woman who was approximately 18 years of age. Mr B is unsure who it was as he can't remember her face or upper body, only her lower body which was naked. This was during World War 2, all the men were away and several families had gathered in Mr B's family's house. The abuser could have been anyone. However, Mr B remembers the room and other details well.

Mr B remembers being led to fondle this woman, there is a gap, and then having his head placed "between her legs". He has a sense he protested but was not heard. No-one else knew anything had happened.

When he was seven years old Mr B's adopted mother once caught him playing with himself whilst playing with a friend. She told him to strip totally and leave home. He was told if he was good enough he could stay for ever after. He tried

very hard to be good. This left him with a strong sense of terror and abandonment. He also had a strong sense of shame about nudity in general, and his own body.

Mr B developed a coping mechanism whereby he would block out any traumatic events that occurred. He is now in the process of remembering events. He has been able to verify a number of the details of his memories and so feels confident these and other events happened.

Consequences of the Abuse

In Mr B's case their are many trauma's in his early life, for example, WWII, all the men at war, and adoption. What Mr B's case shows is how sexual abuse is often a symptom of wider dysfunction especially as his self-report is really no more severe compared to the other mens self-report. The question is really how did he survive so well?

Immediate reactions to the abuse

At the time of his abuse Mr B remembers he was depressed, withdrawn, had low self-esteem and found it hard to trust and communicate with others. He felt very disconnected from his feelings and found it hard to express any feelings or any vulnerability. He felt powerless, unloved, unsupported and wished he was someone

else. He found he built a wall around himself to protect him and from there nurtured his cold-hearted rage over his childhood. However, he could never express this. He found it hard to be with others thinking that "if they know me they will reject me". He developed a fear of women - in fact, to him, women seemed to dominate his whole life. Despite this he has no confusion of his sexuality and is heterosexual - and is also a little homophobic.

Mr B found he became very driven and developed a high need to control himself. He could control his pain, both physically and psychologically, he could become like a robot - this kept others away. Since the time of abuse he developed a wanting to die and saw it as a relief to the pain.

His nightmares had a recurrent theme of being stripped and trying to running but all his muscles are locked up. People are looking on and he cannot cover up.

Mr B developed a problem with alcohol and drank excessively until his second marriage, when he cut down his intake. He thought he was an alcoholic at first but now does not. Alcohol dulled the inner turmoil. Mr B moved a lot. He would go to a new town before he got too well known.

Current reactions to the abuse

Today these feelings and consequences of abuse are still present but to a much lesser extent. He can be intimate but only with his partner - he can cry with her. He is learning to trust himself, but still feels low often. His fears of women and of "being seen" are still strong. He still finds it hard to let others in and receive nurturing. His rage is still very strong and his wall is still there but crumbling. He doesn't have as much need to control himself, nor is he still driven although he retains high expectations of himself. He is still a perfectionist.

Family Dynamics

Mr B was adopted by his aunt. This led him to believe his mother was his cousin. The pain about his childhood was reinforced when he found out he was adopted. He, however, feels a bond to his family. His father was not there much as he worked as a contractor. This left Mr B with no male role-model. Mr B was the `lost child' in the family - he has a strong fantasy world. His eldest sister was his care giver more than his adopted parents.

Within his present marriage he is aware of his own co-dependant behaviour. His major motivation for doing things is so he can please his wife. Mr B says that he used his wife's feelings as a vehicle for his own, at first, but now he is beginning to experience his own feelings.

Disclosure

He always remembered parts of his abuse, but never labelled it as such. He blamed any bad feelings on his adoption. Many psychotherapists would say adoption can be at least as traumatic as abuse. He first realised he was abused while in counselling for his failing marriage, where he described his scant memories. The counsellor suggested it might have been abuse and with further exploration he found it was. He then told his wife

He found disclosure made him feel bad as he finally had to look at himself honestly. This initially put a lot of pressure on his family but later this eased off and his family remained supportive throughout. (In fact during this interview his wife and adopted child were also present). At work he just carried on as usual.

Coping with the Abuse

He rationalised what had happened to him by saying the abuser was drunk. He denied the abuse and suppressed all emotion and most memories of the incident. This is coming back now. He escaped into work and alcohol and simply kept moving from town to town when things got tough.

Current Coping with the Abuse

Mr B is currently working on nurturing the "child" that was hurt. He feels as though he is a child emotionally - that his emotions were frozen at the time of abuse. He is learning to trust himself, his memories and feelings. He wants to feel safe with his anger.

My Assessment

He will need to look at his dependency, only when he is ready to take responsibility for himself and his own feelings will he find healing. He will also need to expand his boundaries, to grow, and learn about how to get intimacy in his relationships.

General Conclusions

Although the abuse was wide ranging and occurred in many forms and places, all the men reacted to the abuse in similar ways. They did not show signs of suffering from PTSD as would be expected from a rape victim. All the men were abused by someone they knew and trusted. They found many other ways to cope with the abuse. I believe they had to do this because no one would believe them and no help was available. Any unusual behaviour was attributed by the men's parents to the fact that they were just boys and this was just part of growing up. Instead the men, as boys, reacted by withdrawing on many levels (emotional, physical, sexual, social), and blaming themselves for the abuse - "I'm no good that's why this is happening to me now!!". Societal factors also effect this. Boys are expected to be tough and if they get into trouble it was their fault and they should be punished for it (Pierce & Pierce 1985). They shut off from their emotions, withdrew and became isolated. They learnt to cope with abuse as a fact of life, and so would often minimise or rationalise the events. Much can be said of their family life in contributing to this. They all had a sense of being abandoned by their families, fathers are noticeably absent, and sometimes mothers. No adult in any of these men's families of origin was available emotionally, parentally, and in most cases physically. Often an elder sibling would provide the basic parenting

requirements. The men withdrew into a fantasy life where they were all-powerful and no one could hurt them.

None of these men tried to reassert their masculinity, in agressive ways. Although as adolescents some acting out behaviours became apparent. All the men felt worthless - "If they know me they will reject me". They developed a fear of intimacy and in many cases of women. This contributed to their withdrawing from the world. Most were confused by their sexuality at the time of the abuse - "Am I gay?", but this confusion had left them by the time they reached adulthood.

The only major psychiatric problem to present were alcohol and drug problems. this is in keeping with the literature (e.g. Stein *et al*, 1988) This features throughout, mainly as a coping tool and as a way of self abuse, as do other addictive traits like co-dependence. Here the men did things to please everyone else, they could never say no. This boosted their self-esteem and self-confidence and everyone liked them. However this is part of the denial for it allowed them to avoid looking at their behaviour and the issues underlying this - "Nothing is wrong with me I'm too nice a guy. I would do anything for anyone". This was a good way of keeping people out.

Most of the men first disclosed in counselling, while in relationships that were not working, where somehow the topic of abuse came up. It was not until this point

that they had to admit something had happened to them. They had to admit they were contributing to the marriage breakdown. This forced them to look at themselves and the problems that lay within. Part of the reason the men ended up in these relationships was the belief in the myth that once you are married everything will be fine. The other is recapitulation of the victim experience. In this case the men chose someone who would fit into the victimizing process, in some way, to be their partner thus keeping the family dynamics they grew up with alive and keeping them victims. How recapitulation and family of origin dysfunction interact is not known. This is a topic worthy of further research.

No evidence of the victim-abuser cycle as put forward by several authors (e.g. Becker 1988, Cantwell 1988) was found. The men were clear they were not about to go out and offend.

All the men reported they procrastinated when confronted with a task they had to do, yet once started they had no problem doing the task. The men said this occurred because they were afraid to start a task in case they failed. To me this points to a very poor self image as opposed to any real problems with doing tasks. "Task" in the case studies took a very wide meaning, anything from washing the dishes to putting a motor back together.

The Group

General Structure of each Group

The group met for five sessions. The sessions were designed so group process could be observed. Group process involves the functioning of the group as an autonomous whole, rather than as just a collection of individuals. Studying group process provides information on how this particular group functions, how these men function as individuals, and how groups of abused men, in general, function.

The groups were structured in such a way as to allow for whatever emerged. I had equipment such as cushions, paper, pens, tissues, and soft toys on hand to help me work with the group.

The evenings followed a fairly typical structure:

1. The group assembled and "centred in" (i.e., became a group rather than a set of individuals) by sharing information about how they were, how their week had been or whatever they wished to talk about.

2. From this discussion themes would develop which the group members decided to work on. This was an interesting process as some themes where the motivation to deal with them was high were kept while others were dropped. This meant at times individuals would forfeit their own wants in favour of the group. Part of my

job was to ensure that themes weren't avoided or emphasized to the detriment of both the group and the individuals.

3. These themes were taken up and worked on in various ways depending on group and individual want (i.e. some men wanted to work and some wanted to watch).

4. The group would review what happened during the night and tie any loose ends. This provided a means of information gathering for this research.

5. My role was as group facilitator and observer of process. I was a group member in this role. We decided as a group what to do rather than me dictating what the evenings session was to be about. This was achieved in true Gestalt fashion by simply following the group foregrounds, i.e the obvious, energized figures that emerged for the group. (For a more detailed examination of this see appendix 2 pg 1.) However, whenever anyone wished to work I took the role of therapist, as I was training in Gestalt therapist and encouraged the group to have any input they desired. When I became the therapist I took responsibility for the pieces of work but not the group process. However, part of being a facilitator meant I needed to do a balancing act between group and individual needs. This is a fine line and I found the group responded well when I pointed out that someone's needs had been ignored.

First Session

The first session started with Mr G, Mr B, Mr D, Mr P, Mr M and Mr V and myself (Mr V chose not to take part in the case studies but had been in a support group with some of the other men. I met him before the group to get his consent).

The first task of the group was deciding whether this group was to be a therapy group or a social/support group. Prior to the group when talking to the men, individually, we had decided this group was to be a support group. After we had discussed the options and implications of a therapy/support/social group, we decided a therapy group was more important. The men also decided to run a support group elsewhere at a later stage. (This, I believe, is an example of the adage from Jan Smuts in the book "Holism" "The whole is more than the sum of the parts", meaning the group's want is greater than that of each individual member.)

The rest of this session was spent in laying ground rules to do with the limits of confidentiality. We decided who was to know what went on in the group, what to do if someone became dangerous to themselves or others (i.e. taking a man into The Psychiatric Emergency department at the hospital, if necessary) and what other support systems they had access to (e.g. Mensline, Lifeline, friends etc.) The men decided everything that went on in the group was appropriate to be included in this thesis apart from people's full names.

We practiced using appropriate language (e.g. "I" statements), and ownership

of language using first person singular so when someone spoke they spoke only for themselves and didn't project anything onto the group or anyone else in the group. Finally the group had an introductory round where people shared how they felt and why they had come.

The men shared briefly their names, family situation and why they were there. Mr B shared how his abuse had been forgotten for so long and how he was now remembering some, but not all, of his abuse. He talked of not wanting to be intimate with other men and that intimacy only happened between men and women. I replied by saying I believed there were levels to intimacy and while I was most intimate with my partner I could also be intimate with him. I said I could demonstrate this by sharing something of myself that I felt was close to me, like the fact that I was scared of how the group was going to go. Mr M also said that for him just being in a group such as ours meant we were being more intimate than most people get to be in their lives.

Mr M then spoke of how hard it was to be here, how he had been battling his addiction in order to just be alive, how much he wanted to get better and how he was prepared to do his own "work". Mr D responded to Mr M with encouragement to "keep on going", saying he enjoyed his company. The other men agreed with Mr D and voiced this with nods and words of agreement.

Mr D then spoke saying he was angry with his abuser and wanted to see him

punished. He had decided to lay a complaint with the police and that he had applied to Accident Compensation Corporation for compensation. The group cheered Mr D's courage by clapping and whistling and then in turn spoke for themselves saying how pleased they were that this was happening. I said I had also decided to apply for compensation. Mr M and Mr B and Mr G all shared that they could not apply because their abuse occurred pre-1974 (pre-1974 abuse is now allowed for) and that this angered them.

Mr V indicated that he found the group too threatening for him and had decided he did not want to carry on after that first session. I acknowledged how sad I would be to lose him from the group and that I knew he was in good hands and I wished him the best. The others shared in a similar vein. At this point Mr M, Mr B and Mr D started to cry as they felt relieved to be sharing some of their pain with people who listened. (This is another example of "the sum of the parts" adage, the group enhanced the depths to which each man could share. This is the point where I realised the group was safe for the men.)

The group ended with Mr G also deciding not to come back because he did not want to do any personal work. The group farewelled the two men who had decided to go and the other four made the commitment to meet again next week.

Analyses

Main Issue : Setting of boundaries so as to provide safety within the framework of a group.

This was a time of sorting and setting the limits for the group. This was important because the men all felt confused with their own limits and boundaries. Boundaries are the points at which contact is made. "Contact" is a Gestalt term, where I, as a separate entity, with a full sense of my separateness can "connect" with thou, who is also a separate entity. Boundaries and hence contact can occur on many levels. The boundaries of main concern here are:

1). The I-thou boundary - the limits to interpersonal contact between group members

2). The body boundary - the limit of allowable body contact

3). Value boundary - the limits of beliefs and values

4). Familiarity boundary - the limits in time, space and geography by which one avoids experiencing the new and different

5). Expressive boundary - the limits to expressing emotions and feelings

6). Exposure boundary - the limits to being exposed and observed

Expansion of the contact boundaries implies growth. Lack of expansion and

lack of growth result from blocks and from reluctance to make contact and to experience what is novel in the environment.

Being abused has left the men with no self esteem or no self identity hence little idea of what is and isn't safe for them. The basic fear in common was they would go insane by sharing what they had inside. This, I believe, is a fear common to many abused people (Lew, 1988). What I noticed was how much more freely the men shared themselves after the group limits were set to the satisfaction of each. I believe the boundaries were satisfactory, they allowed the group to be safe without being so constrictive that the group process stopped. Although the group was safe for Mr V and Mr G they didn't feel safe enough within themselves to want to carry on at this time.

The final point relates to the men crying. Although the content of the sharing had some depth to it, this wasn't really enough to make the men cry. Instead, what I observed was, as the men shared they shared from a place of pain. I judged this from body language such as their postures (eg., body slumped forward, and head hanging), where they held themselves (across their stomaches and chests) and voice tone. Sharing from this place allowed the men to experience a greater sense of intimacy and trust - because someone listened, this allowed for emotional release. The message they received was "You're OK as you are, so, Be Yourself".

Second session

The session started with a "check-in" round where the men talked about their week. Mr B said that for him his abuse was locked up tight inside and he didn't really have any way of finding his memories of abuse. Mr M replied by saying his abuse was too scary to look at and when he thought of it he felt stuck, almost rigid. Mr D said he felt out of control when he thought of his abuse. Mr P said he felt like he just disappeared "into myself - sucked in and turned upside down!". He said he felt like this right now and felt upset as though he had lost himself. I shared that I realised I needed to tread very carefully and needed to facilitate in such a way as to allow the experiences to be healing and not abusive.

I asked the men to draw what they saw when they thought of their abuse and asked them to share this. This was a way to help access these locked feelings. Mr B saw his abuse as a locked box which he had not opened. Mr D saw his abuse as a great mass of colours swirling around out of control inside him. Mr M saw his abuse as a mass of a thick, black, gooey substance, like tar, that encompassed him. Mr P saw his abuse as a black hole inside him where everything was crushed out of existence. The feedback was almost nil as most men were withdrawn and not putting anything out into the group. I affirmed each man as he spoke, acknowledging each persons reality at that moment by saying such things as "I believe you", "I hear you". Although these may be cliches, it seemed important to

affirm each man, because they were saying "THIS IS WHO I AM - AND THIS WHERE I AM WITH MY ABUSE".

I allowed the group to stay with this process because I believe the men were for the first time putting limits to the effects of abuse in their lives. Abuse has no respect for limits; abuse simply invades. To cope many men simply shut off completely, so even if they are invaded they won't have to suffer. I had to be careful not to invade, to allow the men to come out in their own time and encourage them to show themselves to others in the group. I offered to work individually with anyone who wished to go further and then sat quietly as the men explored their boundaries within themselves.

The theme for this evening was finding a way to access to the abuse each person had locked within themselves and trusting to be able to express themselves in the group.

Two men asked to work, Mr B and Mr M. I asked Mr B to build a box from cushions and to tell me about his box. I then asked him what was in the box, but he didn't know. I asked how could he find out? He said he had to open the box. He said he was too scared to open the box up. I asked if he could peek in and tell me what he saw. He did and said he saw a lot of pain and old memories. I then asked if he could bring one old memory out of the box to share with us. He talked of being forced to perform oral sex on an unknown woman (he had said this in the

case study but here he was much clearer and emotional about the whole event). His process paralleled the groups, the theme was one of exposure. He was scared, and rightly so, to reveal all his abuse to the group by opening his box up wide. His worst fears might come true, the group might reject him, or he might become psychotic from the overload of all his abuse coming out at once. Instead by just peeking in he could look at a manageable chunk of the abuse safely for the first time and if people didn't like him, so what!

Mr D replied to Mr B by saying he was very brave and that he liked Mr B. Mr B felt encouraged by this, he said he was pleased at long last to look at his abuse. Mr P said he felt sad at what Mr B had to go through. I suspected Mr P also felt sad with what he had gone through, so I asked him this and he agreed. I pointed out to Mr B that the work he had done was touching people in different ways at a deep level and this was real intimacy. Mr M spoke next and acknowledged he had been touched very deeply and wanted to work now.

The work with Mr M was similar. His abuse filled the whole room with tar so I asked if he could just take a little bit, enough to fit in the palm if his hand, and share this with us, which he did. He shared how hurt he was when his mother didn't believe that her friend had abused him. The whole group sighed. (We had all been holding our breaths, and finally relaxed.)

Mr P and Mr D both responded to Mr M by saying how his work had helped

them to find ways of dealing with their abuse. Mr D said he, in his mind's eye, grabbed one of the colours from his swirling mass. He had found each colour represented some aspect of his abuse, a memory or a feeling. He had grabbed his memory of feeling outraged at discovering his abuser had abused other boys in the corps, and how he wanted to kill his abuser but didn't; he felt powerless.

Mr P said he knew what it was like to feel powerless. He was sick of feeling stuck inside himself. He decided to put some of this out instead of having it disappear into himself. He chose to share some of his abuse and describe how he had become impotent, - sex hurt.

The men in the group were astounded at this and shared their sympathy. The group wound down with the men showing more compassion for each other. They broke off into smaller groups and shared. By this stage the group had ended. All four men had found a way they could tackle their abuse without being overwhelmed by it.

Analyses

Main Issue : The men were now looking at their own personal safety, and their trust of themselves to share their own abuse in the group.

Again we see the process of finding the limits, except now the group is looking at the boundaries to their own abuse. The reason for the change is because they know the group is safe (self-report from the sharing round). Now they have a safe place to explore and reveal themselves, a place where they will be supported and where they know people will understand (empathy). The men were terrified about the possible outcomes of sharing the abuse with others. They believed such things as , "I will go mad", or "people will see how bad and ugly I am if I show them this". One man said "my brains will explode if I say this" However I believed that each of their images also showed the men safe ways of dealing with their abuse. It was a matter of showing the men how to use their images to do this.

The abuse had occurred over many instances. Each instance built on another, layer upon layer, until there was a huge mountain these people carry called "abuse". The men wanted to tackle the mountain in one go but this was too terrifying. To me the obvious thing to do was to reverse the process whereby they accumulated their mountain, and so I asked them to find a small piece of the abuse, a piece they could manage. This process also happened to the men who didn't work. They

found they were "swept along" by the group process and managed to find their own ways to manage their abuse.

This session highlights how group process flows. The men built on what each other said, and this allowed the group to 'refine' what was to emerge as the theme and the work. The whole feel of the session for me was one of natural progression. The group started with a social and settling time. It then moved onto the initial sharing round where everyone got a chance to make contact. From this the theme for the evening emerged as how to set limits to the effects of abuse in the mens lives. This enables the men to feel safe to start exposing themselves so I suggested we draw. This prompted Mr M and B to decide to work. As they worked the group managed to explore the idea of setting boundaries and to find safe ways to express the abuse. Finally we concluded with a sharing round which allowed the men to make true intimate contact with each other.

Third Session

The group started on the third night with Mr P not turning up. This caused discomfort for the others. Mr D said this was typical of the people in his life, and he often felt let down by his family. Mr M said he felt the same way and he was

angry at not being heard by his parents particularly with regard to his abuse. Mr B said he never felt close to his family and was disgusted by their apathy regarding his abuse. I shared how I felt disassociated from my family and relieved to be out of their system. The others agreed with me. By this stage Mr P was 30 minutes late and so we decided to start without him.

The group decided to look at being abandoned by our families. As we shared our experiences of this, the group became more cohesive. Mr B shared how he was adopted by an aunt and thought of his mother as his cousin. His father was never there and so he had no male "role model". He withdrew into his own fantasy world and felt very shut off from the family. I asked if he would like to do any more and he said he would like to just sit for now. He looked to me to be reliving his painful experiences. Mr D moved closer to Mr B and put his arm around him to show his support.

Mr M shared how he had been abused in his family, how his father would persecute him and his mother would rescue him from his father. He felt tossed around and unwanted. I asked if he could tell his parents this now, using a cushion to represent them. He did and got very angry, beating the cushion and screaming at his parents telling what a terrible life he had led as a result of their actions. He said he enjoyed showing his anger because he never had before "I am just so angry with them, with my life - It is a shambles". He felt powerful and in control by

telling them how he really felt. I said he looked magnificent. Mr B agreed.

Mr D shared how he felt like his parents didn't really know he was alive "I was just seen and not heard - I felt totally lost and unsupported." He cried for about 15 minutes, allowing himself to express this fully. The group came around to support him and we were aware not to crowd him but let him finish in his own time. When he finished he said he felt great as though he had finally released some of his burden. The colours were no longer in a big mass inside him but had began to sort themselves out. He shared that he could love himself for the first time. The rest of the group were obviously very touched by this from the feedback they gave.

Mr M shared how he had never been able to cry yet when Mr D was crying he was crying with him, inside (I could see the tears in his eyes) and how he felt he too, had less of a burden to carry.

Mr B said he was ready to do some work now. Mr B shared how touched he had been and how he wanted to experience the same discharge. I was immediately suspicious of this as I couldn't be sure he wasn't just "jumping on the bandwagon". I did not believe he was ready for such a release yet as his box was still firmly locked.

I asked what he would like to do and he said he wanted to talk to his mum so I asked if a cushion could become his mum. This was OK. He told her how much he had missed her, how he had and still needed her, and how he sometimes

felt like he just wanted to be nurtured. He stopped and said he was finished. There were no dramatics yet he did feel a sense of relief that he finally admitted how he still hurt, and needed to grow up and find a mum. I asked where he could get the mothering he wanted. He said from himself mainly, by taking care of himself and from his wife and other friends sometimes. Mr D said how important he found it was to be his own parent, to love and care for himself. I said I found this was also true for me. Mr M said how much he missed being parented and had found some people who were role models for self-parenting within the 12 step fellowship he attended. The group concluded.

At the end of this session Mr D said he would like to finish with the group as he had got enough out of his work and needed a rest. The group encouraged him to take a rest and said goodbye to him. I acknowledged his need to stop and reminded him that he was in the early days of his recovery. He said he knew this and he had the support he needed.

Analyses

Main Issues : i. To break the silence and thus stop the denial.

ii. The importance of being one's own parent

The power of abuse lies in the fact that it must be kept secret; the abused child can tell no one of the abuse because they will not be believed (denial by

others, another abusive process). In this group, even when the men spoke of the abuse to close relatives they were not believed (I believe this may be more of a problem for men than women because of sex role stereotypes - men abuse, women are abused, so the men were not believed. This stuff just didn't happen to boys). Once the men feel safe enough to deal with the abuse the next step is to stop denying they had been abused with significant others. As the men spoke about their families and how they felt abandoned, the reverse happened in the group. The group became more cohesive and my sense of this group was it was safe to share some of my most intimate details here. This was reflected in how the other men also shared.

This process was set off by Mr P not turning up. The men saw this as abandonment because Mr P had not communicated to anyone his intentions for the evening. We all expected him to be there; he was not and we felt he let us down. This message reads "I can't rely on you, you're never there for me, I can't get my needs met, I feel alone, abandoned." "I feel abused by you." We are talking about people who were starved emotionally, and the only love they knew was abuse. In contrast, when Mr D decided to leave, the group did not feel abandoned but encouraged Mr D's actions. The difference was Mr D clearly stated his intentions to us all; he was "straight" with us. We knew where we stood with him.

The other point is often men (abused or not) are emotionally immature,

especially as they want to have full intimate relationships with others. As a result of this, these men need to find ways to emotionally mature. In other ways they are as mature as anyone else (e.g. they all held jobs and they all had families and did these things as well as anyone else). One way is to re-parent themselves, as the best role-models for learning about intimacy were our parents. For these men the best way to learn about parenting was to acknowledge how badly they were parented and then from there to find what they do want from a parent and how they can give this to themselves.

Fourth Session

The fourth session was to be the last as a therapy group. Mr B wanted to work straight away and Mr M wanted to share, but not work, as he was tired from his working day. Mr B wanted to work on being present as he would often disappear into a day dream and withdraw his feelings, keeping them to himself. He did this because he feared exposing himself, in case he got invaded (i.e. fear of intimacy.) This came up for him when he tried to share with his wife during the week some of the things he discovered last week but couldn't - "It was like I just left the room". He started doing this as a means of surviving his abuse and "leaves his body" whenever threatened. He discovered that by looking at someone he could trust (Mr M) he stayed "present". He found this very frightening as this meant he

had to be intimate with Mr M and the only intimacy he knew was abusive. With support and some relaxation techniques he slowly allowed himself to be honest about how he felt inside, and as no one pushed or wanted something from him, he felt he could be more and more bold. He could share how he felt with the person. This had taken most of the group time and so we talked about the piece of work and the dangers of being bold with others when they might not support you. Mr M said he was afraid that a" big scary monster" would get him whenever he shared, although he knew the only scary monster around was one he had created. I shared how much I had seen Mr B grow and how much more I was enjoying him. The group also decided to finish next week as both men said they had got all they wanted for now and decided to return to private therapy. The group decided to invite the others who had left and to finish off somehow. I would also gather some information for this thesis at a concluding session.

Analyses

Main Issues : i. To be able to be in contact with others (i.e. intimacy) and not desert themselves.

ii. Finding appropriate ways to end the group.

The numbers dwindled and the group life had come to a close. I found this

interesting as having such a small group (three) the energy for a group just wasn't there. The men decided they had done enough in a group for now. However the men's energy for change was present in the group.

The heart of this session was about overcoming fear of intimacy so the men could be "present" with each other. At the centre of this fear lies exposure of one's self. For these men any amount of exposure is difficult as they learnt early on that to expose themselves meant risking invasion by an abuser. Thus, learning to be present with others is a difficult skill that takes time to develop and to apply. The best way I could help Mr B discover intimacy was by exposing him to intimacy in a practical, safe setting. He opened himself, gently, becoming more intimate with Mr M and slowly he relaxed (with some help from me) and started to learn to trust the group. He needed to see he wasn't going to die if he told someone how he really felt. This session was just the start for both men, especially Mr B.

Closing Session

The next week was the last session with Mr B, Mr D, Mr P, Mr M. This session ended up being a chance to catch up and find out what had been going on with everyone, as well as an opportunity for me to gather some data.

Mr D shared how he got full compensation from ACC and how he had laid a charge against his abuser. He was attempting to make contact with the other men

who had been abused by this man to gain support for his case. The group thought he was doing just fine. Mr M offered him support and help in any way Mr D wanted. He attributed some of his courage to being in this group.

Mr B shared how much he got out of the group and how well his relationship was going. He was bubbling over with joy. Last week he was able to make significant changes to the way he related to people, especially his wife. Mr D said he was impressed at the changes he saw. Mr M and I added our agreement.

Mr M said that his home life had improved. He found he was able to control himself and his addiction much better. He also said, after I challenged him, that his work could become a new addiction. I wondered if he might consider being more flexible with his work hours, i.e. doing less overtime. He agreed that this needed to happen.

Mr P only stayed for 20 minutes. He remained withdrawn and when the others tried to make contact with him he would not engage with them. He did say he discovered some issues he needed to deal with, as a result of the group, but would go no further in this discussion.

I spent most of the evening talking to each man individually in order to gain more information on this group. This was done after the men had shared and the group had formally closed.

I discovered the reason for dropping out of the group was that these men had

got what they wanted. On questioning the men I discovered they all knew they moved on when things started to get intimate in their lives. This is a life pattern of avoidance of intimacy which is part of them abusing themselves, the "inner abuser". This time in facing the abuse they changed a process of avoidance and allowed further changes to occur. Having experienced one group where there was safety, support, and therapeutic skills available, there is the possibility they will want to continue working in short-term groups on all the other issues that this short space of time allowed them to glimpse. Issues like boundaries, conflict, abuse and abusing, parental needs (the men's own needs to be parented as well as how to parent in order to not perpetuate the abuse cycle), roles, control, addictions, and the paradox of change.

Follow Up: The Men After The Group

Mr G needed to take time out from working on his abuse and carry on with life. He was looking at forming a support group with some of the other men, but was not interested in doing any therapy for the moment because he had difficulty feeling. He is aware of many emotions boiling away under the surface and right now they scare him.

Mr G seemed to me to be a lost soul. He was full of bright, great ideas but lacked something to finish them with. He has a good, intellectual understanding of his abuse and abuse in general, yet he wasn't prepared to allow his emotions to show. These were still under "lock and key". He left the group after the first night because he found expression of his emotions very difficult. This represents a very early stage of recovering from abuse (see Process of Recovery in Appendix 1). I believe he has many unresolved issues to deal with.

Mr P rang me just before the fourth session. He said he had got what he wanted out of the group and did not wish to carry on. He said he became aware that therapy was not for him right now and he too needed a support group. He made no apology for not turning up on the group night. His manner was short and he sounded very angry when he talked to me. When I asked him if he was angry he

hung up without a reply. This was unexpected as the last group he attended he said was great and he was looking forward to the next group. He did turn up to the last session, however, but he remained aloof, withdrawn, and would not come out when group members tried to engage him in conversation. He left shortly after the other members commented how cold he was.

Mr P denied his anger towards me, other group members, and the group for making him be in this project. (I believe he would deny this though). His choices regarding participation in this research were made very clear by me. He left participation in this project with a lot of ends dangling. I believe his anger was displaced and belonged with his abuser. Instead, he gave his "power away"(i.e. not taking responsibility for himself or his actions) so he could blame everyone else when he felt uncomfortable. He had the opportunity to look at the issues around his abuse but this wasn't the right time for him to do this. Some things were brought up for him but I am not aware if they have been resolved. He was seeing a very competent therapist and I believe he is well supported. I believe he is very STUCK.

Mr D said the group helped him accept himself. He learnt he can love himself and he take responsibility for himself. He saw he no longer needed to approach the world "as a leper". He was just the same as other people and maybe a shade more

interesting. He became aware how he could become a tool for helping others after watching me in action (I felt pleased by this). Mr D has yet to deal with his marriage break-up. He has not fully expressed his anger around this, but is starting to. I do not believe his anger scares him anymore. He has dealt with his family, to some extent; he told them how he felt during his childhood. This resulted from the group session looking at being abandoned by our families. He is more aware of his limits and how far he is willing to go and be intimate with people. He felt more able to be in control and to control his abuse - he is not longer scared he will go mad.

Mr D decided to press charges against his abuser and also received a lump sum payment from the Accident Compensation Corporation. To me these are signs of a man who is dealing with his abuse, I believe his prognosis is very good. He is aware of his limits and of the unresolved issues AND is prepared to deal with them.

Mr B acknowledged how much he had changed as a result of the group. He found he was able to share more of himself with his partner and family. He found at long last he had made some changes and he felt good about himself. He also saw he had a long way to go, especially with his wife, and wondered if he would ever reach a place where he would feel complete. He believes he is now equipped to carry on

the process of change. Before the group he didn't know where to go or what to do - he felt lost. He said he could now get access to the abuse and he wasn't frightened of being swallowed up by his memories of the abuse. He was able to share his memories and his pain. By doing this he felt like he was emerging from a fog.

Mr B has the support of his family; however, I also saw a great deal of co-dependence within his family. He does everything to please his wife, even joining this study (when I interviewed him, his wife answered as many questions about him as he did). He is aware of this. The impression I am left with is someone who pleases others but not himself and I wonder if he will ever get what he wants; if he will ever open the box and see who he really is. Because he made good progress in the group I believe there is hope for him. But he needs to keep doing his personal therapy otherwise he will disappear into the box again. He seemed to want to be himself with others (he was the man who worked on being present and intimate with others in the last therapy session). I believe Mr B's path takes a lot of courage and like the tortoise he will complete the race, slowly but surely.

Mr M said he felt really good after the group. He felt like he was in control of his life again. He was more open with his wife about what was going on for him. He found the group challenging, and he enjoyed the challenge. He was aware of

needing to juggle his job with his personal therapy, and this has been hard. So he would sometimes hold back in the group. He had accepted himself, his abuse, his addiction, and that he would have to live with both abuse and addiction for the rest of his life. He accepted himself just as he was. He forgave himself for enjoying the abuse when it first started - "no one should have to go through this". He realised he needed to do more work if he was going to recover and had made plans to see a therapist.

Mr M has addiction problems to deal with as well as abuse issues. Although he was receiving support from a 12 Step Programme, I found he was avoiding his problems by becoming immersed in the new job he had started, to the extent that family and friends were a definite second, thus replacing one addiction for another. I believe he can look after himself. He is yet to learn to live one day at a time.

Envoi

The emphasis in this thesis is on the use of qualitative research methods. These methods are used to describe peoples experiences in their own terms. This allows us to get a better picture of how the world really is rather than how we assume the world is.

The world of the men studied is a world of much pain, shame and confusion. They show a great deal of confusion over who they are, who they can trust, and what they can believe in. They come from homes were they were not allowed or able to share their pain. They received no support there and in many cases were abused. Thus, they learned to adapt; people could not be trusted, so they withdrew into their own fantasy world in which they lived out their lives where no one would hurt them. As they grew they were unable to enter the real world as mature adult men. They were trapped in the pain of their abuse. Lacking knowledge and security about themselves they fell into relationships that did not work in the long term, and in some cases ended up re-enacting their childhood abuse with their partners. Some turned to drugs and alcohol, some to work, some to moving and others withdrew even more. At some point all realised they needed help, and eventually found it.

This is the legacy of childhood sexual abuse for these men. The main objective of this thesis was to research this legacy in such a way as to bring about

understanding of what this epidemic is like for those who suffer from it and to expose the myth that men are not affected by childhood sexual abuse. One criteria for feminist research is about enpowerment.. I hope the enpowerment the men gained will spread through them to wider society. Enpowerment comes when these men share the responsibility for their data. In the case studies this was done by a process of two-way communication whereby the men can see and objectify what had happened to them. They are also empowered by having in the data only what they believe needs to be included. Too often researchers take peoples "power away" by treating them like unthinking strangers, and as is reported in this thesis, this effect is multiplied in abused people. However, these men were co-operative in assisting me with re-writes of their case studies.

The group, by its very nature, was empowering, giving these men a chance to explore and "work" psychotheraputically through some issue of importance to them. One point about the group is the number of dropouts. The reason for this was the purpose of the group was not fully decided upon until the men arrived. Since this time I have ran other similar groups of 10 weeks duration successfully, with one in ten dropping out. The lower dropout rate results from being much clearer from the outset what the group is about, i.e. personal work. Due to the nature of the research I did not think I could impose such limits. I now believe it would have been better to have made a clear decision, including all the men in such a decision, and stuck

with this before the group started. This allows the boundaries to be set. In working with abused people where so many boundaries have been crossed, this is very important. The effects of sexual abuse are tragic. This thesis describes results very similar to those of overseas studies. All the men were abused by someone close to them, someone they knew and trusted. A major area of research and concern with male child sexual abuse is the fear of homosexuality. The men in this study had some concern as children. However as men these fears have gone and the men feel comfortable with their sexual identities. The men showed no effects from adolescent acting-out behaviours, such as aggressiveness, conduct disorders etc, although this was present in their adolescence for a few men. As adults these men want to get on with their lives and in most cases are responsible parents.

These men have shown some signs of recapitulation of the victimizing experience, not as abusers but as victims, by getting involved in dysfunctional relationships. All the men grew up in dysfunctional families, and their relationships reflected this. It is hard to tease out which factor has the greater effect here, recapitulation or dysfunctional family. However they are aware that this is a problem and are attempting to deal with this by learning about themselves and about intimacy. Intimacy has shown up as a common fear of all the men.

These men have all displayed some form of psychiatric disturbance, in terms of suicide, depression, and anxiety, and in two cases, substance abuse. Only one case

of sexual dysfunction was reported, with the others acknowledging some form of over-active libido. These men were all aware of not being or wanting to be abusers of others, none would admit to having fantasies about children and found this idea repulsive.

This is a preliminary report on male child sexual abuse. The true effects in New Zealand have yet to be explored. One hope for this thesis is that it may pave the way for futher research of this nature and, ultimately, for theory construction.

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APPENDIX 1.

INTERVIEW CHECKLIST

DEMOGRAPHICS

Age

Marital Status

Children

Place in family

Work

Hobbies

Educational Background

Health

DESCRIPTION OF ABUSE

When did it occur

How often

Who was involved

Did anyone know

Where did you get your support, if any

What type of abuse was involved

SYMPTOMS AND CONSEQUENCES

EMOTIONAL

Withdrawn, depressed

Low self-esteem e.g. feel ashamed when complimented

Hard to trust others

Hard to talk to others

Fear of intimacy

Can't express vulnerability

Frozen emotions, fixated at one incident

Disconnected from feelings

Feels helplessness

Wish you were someone else

Feels unloved

Feels unsupported

Feels guilty about abuse

Shameful

Feels that they live in another world, isolated from the rest of us

Fear of expressing emotion e.g. anger

Feels angry, wants to kill

Wants revenge

Jealousy

Envy

PSYCHOLOGICAL

DRIVE

Doesn't seem to be able to concentrate on task

Procrastinates, lack of drive

CONTROL

Pathological need to be in control of self

" " " " " " of others

Need to pretend that not in control (helplessness)

FEAR/PHOBIAS

Fear of being seen/ of exposure/ agrophobia

Development of fears and phobias e.g. women, men, authority, rules etc

Nightmares

SEXUALITY

Confusion of roles/identity/sexuality

Excessive sexual behaviours e.g.masturbation, acting out, promiscurity, knowledge

ADDICTIONS

Complusive overeating/not eating/bingeing/etc

Complusive washing of body and clothing

Other addictions

CONTACT

Inability to recieve nuturing/comfort

Find it hard to connect with other people

If they know me they will reject me

Secretive

Can't say "no", always need to please others

Depersonalisation

ABUSE

Linking abuse with love

Blames self for abuse

Self abuse

Flashbacks

Suicidal gestures

Wanting to die

OTHER

Eating, sleeping, elimination disturbances

Regress e.g. Bed wetting, thumb sucking

Cry excessively

"Out of body" experiences

Running away

Truancy

Criminal behaviour

Other forms of violence

FAMILY DYNAMICS

ROLES
Hero

Rebel

Lost child

Mascot

TRENDS IN FAMILY

Rescuer

Victim

Persecutor

OTHER (e.g.child takes on parental role)

ABUSER

Remember abuser

Parent

Drug or alcohol abuse

In a physically or sexually abusive relationship

Blame child for abuse

Denial of abuse

Threats or revengeful behaviour

Sorrow/repentent behaviour

Other responses

PARENTS

Aware of abuse

Offered support

Denied abuse

Blame child for abuse

Drug or alcohol abuse

Physically or sexually abusive relationship

GENERAL

Breakdown

Divorce

Poverty

Relationship between abuser and family

Other stressors

HOW DID YOU KNOW IF YOU WERE ABUSED?

WHAT CAUSED YOU TO REMEMBER?

WHAT CAUSED YOU TO DISCLOSE?

TO WHOM DID YOU DISCLOSE AND WHY?

CONSEQUENCES OF DISCLOSURE

Self image

Emotional

Personal relationships:- intimacy, support

Relationship to family, children, etc

Work problems

Other stressors

HOW DID YOU SURVIVE?

At the time of abuse?:- behavioural, psychological etc

COPING MECHANISMS

Rationalise- he was drunk

Minimise- I didn't die, only happened once

Denying- it didn't really happen

Forgetting- forgetting parts of childhood

Being alert- hypervigilance, ultra sensitive

Humour- deflect pain

Busy-ness- aviod present moment

Escapes- addictions, psychotic states etc

Fantasy

Other strategies

PROCESS OF RECOVERY

STAGES OF RECOVERY

1. Decision to heal

2. Emergency state

3. Remembering

4. Believing it happened

5. Breaking silence

6. It was not your fault

7. The child within (bring the abused child out)

8. Trusting yourself

9. Grief

10. Anger

11. Disclosure and confrontation

12. Forgiveness (of self?)

13. Spirituality

14. Resolution and moving on

APPENDIX 2.

Adapted from an assignment based on the theory of Gestalt

GESTALT ASSIGNMENT

1. FIGURE AND GROUND

Figure - the energised focus of attention

Ground - the environment. Our perceptual field.

The interplay between figure and ground is quite dynamic, for the same ground may, with differing interests and shifts of attention, give rise to different figures; or a given figure, if it contains detail, may itself become ground in the event that some detail of its own emerges as figure: Such phenomenon is, of course, 'subjective'.

The figure is that which I choose to give my focus of attention to at any particular time.

*

AWARENESS

Sensing and experiencing of what is outside you and or what arises in you.

Awareness is the flow of aliveness.

Awareness is ....

This continuum of awareness seems to be very simple, just to be aware from second to second what's going on. Unless we are asleep we are always aware of something. However, as soon as this awareness becomes unpleasant, most people will interrupt it. Then suddenly they start intellectualizing, bullshitting, the flight into the past, the flight into expectations, good intentions, or schizophrenically using free associations, jumping like a grasshopper from experience to experience, and none of these experiences are ever *experienced,* but just a kind of flash, which leaves all the available material unassimilated and unused. * 1

That awareness per se - by and of itself - can be curative. Because with full awareness you become aware of this organismic self regulation, you can let the organism take over without interfering, without interrupting; we can rely on the wisdom of the organism. * 1

Awareness covers so to speak, three layers or three zones: Awareness of the *self,* awareness of the *world,* and awareness of what's between - the intermediate zone of fantasy that prevents a person from being in touch with either himself or the

world. This is Freuds great discovery - that there is something between you and the world. * 1

3. **RESPONSIBILITY**

To take responsibility for my own reality and responsibility for self, responding from who I am.

I think of the Gestalt concept of the individual being responsible for his feeling thinking and behaving as grounded in the basic assumption that everyone can be self supporting and need not manipulate others in order to survive.

The world is not there for your expectations nor do you have to live for the expectations of the world. We touch each other by honestly being what we are, not by intentionally making contact. Responsibility in one context is the idea of obligation. All it means is I have a duty - I believe I have a duty to support this person. Responsibility can also be spelt response ability: the ability to respond, to have thoughts, reactions, emotions in a certain situation. This responsibility, the ability to be what one is, is expressed by the word *I*. **Responsibility means simply to be willing to say I am I and I am what I am.**

Language : His troubles worry him - when indeed he is worrying himself and anybody else he can. * 4

In Gestalt Therapy, RESPONSIBILITY literally means "the ability to respond".

You can only respond when you are fully aware of your behaviour and of your choices; then, on the bases of your awareness, you can freely choose what to do. Taking RESPONSIBILITY is therefore an ego function, or an "I" function. We avoid taking RESPONSIBILITY by introjecting, projecting and retroflecting. In order to take RESPONSIBILITY, first we need to become aware of our irresponsible behaviour. One way we can recognize it quickly is by paying very close attention to our language. RESPONSIBILITY IS: THE ABILITY TO RESPOND * 3

4. HOMEOSTATIS

'We all have an instinctual need to attain Equilibrium through the fulfillment of our needs. When we succeed in achieving balance, our state of being is called Homeostasis. Any pressing need creates an imbalance. The organism will consciously or unconsciously seek the means to regain balance - to attain Homeostasis.' (Peeling the Onion - Jorge Rosner, Pg 42)

To bounce back and forth in search of balance. The point of creative indifference. When you have met the need you bask, and are basking in a holy state. A state of grace.

5. CONTACT AND CONTACT BOUNDARIES

Contact is the point of I and thou, contact occurs in the now when we perceive a clear figure in our environment, this implies a clear sense of self. " There is no

awareness without Contact although Contact may occur without awareness " (Rosner pg 35). Contact contains an inherent paradox; contact seeks union yet it can only be achieved when you have a sense of self as separate.

A distinction can be made between contact, withdrawal, and isolation. Withdrawal is making contact with one's self, it is characterised by being of short duration and is a time to "recharge one's batteries". This occurs naturally when we sleep or meditate and when we withhold our awareness from the environment. Isolation is the opposite of contact, here one severs contact with the environment, this is a prolonged seclusion from the world outside.

The contact boundary is where one experiences a sense of self as opposed to that which is not of one's self. This point is the contact boundary, or the I-boundary. Resistances are seen as disturbances of this boundary where the sense of self is blurred in relation to the not self.

There are other boundaries where contact can occur:

1). The body boundary - the limit of allowable body contact.

2). Value boundary - the limit's of belief's and values

3). Familiarity boundary - the limit's in time, space and geography by which one avoids experiencing the new and different

4). Expressive boundary - the limit's to expressing emotions and feelings

5). Exposure boundary - the limit's to being exposed and observed

Expansion of the contact boundaries implies growth. Lack of expansion and lack of growth result from blocks and from reluctance to make contact and to experience what is novel in the environment. *7

6. RESISTANCES

Projection

Disowned qualities, attitudes or feelings which are placed onto objects or other persons. To project is to place outside of yourself what you do not want to acknowledge ownership of.

A projection is a trait, attitude, feeling or bit of behaviour which actually belongs to your own personality but is not experienced as such; instead, it is attributed to objects or persons in the environment and then experienced as directed toward you by them instead of the other way around. The projector, unaware, for instance, that he is rejecting others, believes that they are rejecting him, or, unaware of his tendencies to approach others sexually, feels that they make sexual approaches to him.

This mechanism, like retroflection and introjection, functions to interrupt mounting excitement of a kind and degree with which the person cannot cope.

Retroflection

The retroflector abandons any attempt to influence his environment by becoming a separate and self-sufficient unit, re-investing his energy back into an exclusively intrapersonal system and severely restricting the traffic between himself and the environment. *5

Here you do to your self want you want to do to the other person or want the other person to do to you, so you "substitute yourself in place of the environment as the target of behaviour" and turn your energy back in on yourself. This often shows up as a physical symptom due to the repressed tension in the body. * 4

In social situations it is usually advantageous to suppress a tendency to go off half cocked (but if fully cocked, aimed and ready, it may be quite a different matter). * 1

It is only when the retroflection is habitual, chronic, out of control, that it is pathological; for then it is not something done temporarily, perhaps as in an emergency matter or to await a more suitable occasion, is a deadlock perpetuated in the personality. * 1

Furthermore, since this stabilized battleline does not change, it ceases to attract attention. We forget it is there. This is *repression* - and neurosis. * 1

Introjection

To take in without question values and belief's from the organism's environment is to Introject.

Healthy introject's:

- weather forecast's.
- avoidance of danger.
- traffic rules.

The introjector invests his energy into passively incorporating what the environment provides. He expends little effort in specifying his requirements or preferences. This depends on him remaining undiscriminating or in an environment which is totally benign. As long as he stays in this stage, when the world behaves inconsistently with his needs he must devote his energy to keeping himself content with taking things as he finds them. *5

An introject consists of material - a way of acting, feeling, evaluating - which you have taken into your system of behaviour, but which you have not assimilated in such fashion as to make it a genuine part of your organism. You took it in on the basis of a forced acceptance, a forced (and therefore pseudo) indentification, so that, even though you will now resist its dislodgment as if it were something precious, it is actually a foreign body.

Both as an organism and as a personality one grows by assimilating new material. To compare the acquisition of habits, attitudes, beliefs, or ideals to the process of taking physical food into the organism strikes one at first as merely a crude analogy, but the more one examines the detailed sequence of each, the more one realizes their functional identity.

Physical food, properly digested and assimilated, becomes part of the organism: but food which "rests heavy on the stomach" is an introject. You are aware of it and want to throw it up. If you do so you get it "out of your system." Suppose, instead, you suppress your discomfort, nausea and tendency to spew it forth. Then you "keep it down" and either succeed finally in painfully digesting it or else it poisons you.

When it is not physical food but concepts, "facts," or standards of behaviour, the situation is the some. A theory which you have mastered - digested in detail so that you have made it yours - can be used flexibly and efficiently because it has become "second nature" to you. But some "lesson" which you have swallowed whole without comprehension - for example, "on authority" - and which you now use "as if" it were your own, is an introject.

Though you have suppressed your initial bewilderment over what was forced into you, you have cluttered you personality with gulped down morsels of this and that, you have impaired your ability to think and act on your own. *1

Deflection

Healthy deflection takes the heat out of violent situations.

Avoids direct contact, the joker. Dilutes meaningfulness. Talks about anything but the point ad nauseum.

The individual who deflects what comes towards him, by shrugging off what is said or by explaining everything away, experiences himself as unmoved, bored, blank, cynical, unloved and unimportant. On the other hand, the person who deflects his expression, by qualifying each statement or talking in a round about way, often feels he is not getting much out of what he is doing. He "tries" but never gets the rewards for his efforts that he wants. * 8

The person blames outside sources for feelings; he denies his responsibility ... especially through the misuse of language. * 8

Deflection is a manouver for turning aside from direct contact with another person. It's a way of taking the heat off the actual contact. The heat is taken off by circumlocution, by excessive language, by laughing off what one says, by not looking at the point, by coming up with bad examples or none at all, by politeness instead of directness, by stereotyped language instead of original language, by substituting mild emotions for intense ones, by talking 'about' rather than talking 'to', and by shrugging off the importance of what one has just said. * 5

7. THE GESTALT CYCLE

This is the cycle of Gestalt Formation. The cycle refers to the on-going process as the organism meets its needs and returns to homeostasis. Gestalt formation involves sensation and perception of self and/or environment, awareness of feelings,ideas and needs, mobilization of energy to express or hold in, this causes the organism to get excited or anxious (seen most obviously in the way the organism breathes), the organism must then act on this excited or anxious energy to expend or release the energy, with action comes contact with the environment and/or self, the energy expended, the cycle completes by the organism returning to withdrawal and rest awaiting a new cycle to begin and the flow to continue. Unfinished business arises when the cycle cannot be completed. Energy and attention are tied up with the unfinished Gestalt, however so homeostasis can be achieved this energy gets re-directed to a place where a Gestalt can be achieved and thus attempt to fulfill the first Gestalt, this is called sublimation.

8. UNFINISHED BUSINESS

Inner experience colours and determines current experience. Just as a hungry individual perceives food, even when it isn't there, so does another unsatisfied person continues to work out, in his current activities, unfinished business from his past.

"... although one can tolerate considerable unfinished experience these uncompleted experiences DO SEEK completion and when they get powerful enough the individual is beset with preoccupation, compulsive behaviour, wariness, oppressive energy and much self defeating activity."

"...tells the same story over and over because he feels he has never been heard."

"Once closure has been reached & can be fully experienced in the present, the preoccupation with the old incompletion is resolved..." * 5

There is an apocryphal story, variously attributed to Bach, Handel or Haydn, wherein the aged maestro prepares for bed and hears a friend playing the clavichord downstairs. The friend plays beautifully and the music builds but ends abruptly, on a 'dominant' chord! Now, in those days dominant chords were inexorably resolved by leading into the tonic and final chord. The maestro, restless, tossed and turned in his bed but could not fall asleep until he tramped downstairs and banged his resolution into the clavichord. * 5

9. POLARITIES

No quality or attribute exists without its opposite.

The polarity most often dealt with in Gestalt Therapy is the TOPDOG/UNDERDOG split. The TOPDOG is the master, the "should-er" or

authority figure, and is often a petty tyrant. The UNDERDOG is the slave, little boy or girl, saboteur, or victim, who is always being picked on and "controlled". Both sides need to be acknowledged, accepted and integrated. However, what usually happens is that the TOPDOG regects the UNDERDOG, which then has to find other ways to survive.

Intergration is only possible when both sides of the polarity are clearly articulated and experienced. Each side must find a way to assert its wishes so that a new creative solution can be found - one that is expressive and inclusive of the wishes of both sides. * 3

The basic requirement in working with polarities is to restore contact between the opposed forces. Once contact between the parties is established, each party to the warring struggle can be experienced as a valid participant. They can then become allies in the common search for a good life, rather than uneasy opponents maintaining the split. Almost invariably, when contact is restored, the individual discovers that these distrusted parts had many redeeming features and his life expands when these are recovered.

10. THE PARADOXICAL THEORY OF CHANGE

Change will only occur when people want to change. When people have fully invested their energy in being what they are, in the now, then they release this energy and are ready to move on, to change and become what they want to be. 'Change comes about when one becomes who one is and not when one tries to become what one is not' (Beisser - quoted Gestalt Therapy and beyond _ Markus pg 214).

This statement is predicated on four related principles.

1. There is a natural self-regulating process inherent to existence - a human if allowed to function without constraint and interruption will take best care of itself, and will be sensitive to the needs of others as well.

2. Taking care of oneself begins with taking responsibility for how one is not taking care of oneself.

3. A human is integral with its environment and thus peace of mind is partially a function of accepting what fate bestows upon us all including our inability to live up to our ideals.

4. A human is capable of disowning, misapprehending, or distorting knowledge of its experience and behaviour. * 2

When we fully accept who we are, change can take place. The more we 'try' to

change the worse the our situation becomes. The more we get in touch with our own experience the easier it is for change to occur, without effort. The Paradoxical Theory of Change asserts that only by accepting - not fighting - how and who we are can change occur.

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APPENDIX 3.

This was taken from a review of Claudia Black's book on adult children.

"It will never happen to me!"

With these words every child of an alcoholic has spent a life-time of hurt and avoidance. For those who think they have been lucky enough to make it into adulthood without becoming addicts themselves, this book comes as a very rightening realisation. Why? Because they too are affected.

> As the author, Dr. Claudia Black, says, "Yet, the words "It will never happen to me" were thought and spoken in all sincerity - those children, as adolescents and adults, honestly mean them. And, after working with the adult children, I knew, in all sincerity, their children would echo the same words" Pg. 12.

Thus begins a book that has taken the field of addiction by storm because it was the first to fully treat addiction as a disease involving the whole family, and in particular, the children (called COA's or ACOA's - Adult Children of Alcoholics). The book can be divided into two parts.

The first part looks at the process of growing up in an alcoholic home: 1) The roles taken on by these children;

2) How these roles are maintained through the process of denial; 3) The effect

these roles have on the children as adults.

The second part of the book is a self-help section concentrating on **ACOA's** both as children, still in the home, and adults, away from the home, with useful material for the helping professions. The **book** ends with a chapter on resources. This review will follow this overall structure.

The book looks at roles that develop in children in an addictive family system. The reason these roles develop is quite simple: the children adopt them as a means of surviving in the family system. Dr. Black says that smoothly working families exhibit consistency and predictability, this allows the children to grow and learn in a safe environment. However, in an alcoholic family, inconsistency and unpredictability reign. In a well functioning family emotions tend to be expressed clearly, and the family accepts, supports and encourages this expression. In the alcoholic family emotions tend to be repressed and become twisted, if shared they are normally expressed in a spiteful, blaming manner.

Dr. Black found that although there is usually one child in a family who produces problematic, delinquent behaviours, the other children, of the family, don't produce these behaviours, in fact, they seem very well adjusted, doing well at school and university, being responsible at home and always helping others.

Although these seem like well adjusted behaviours Dr. Black found they aren't. For example, these people not only have to do well at school, sport or whatever but they have to be the best and unless they get an 'A' or come first, they feel they have failed as people - in short they are super perfectionists. In fact many have missed their childhoods by being super-responsible - they become parents to their parents, doing the housework, cooking food etc., even at the ages of 9 or 10. Dr. Black found many more of these behaviour patterns in ACOA's and discovered that they centered around four groupings or role types called Responsible Child, Acting Out Child, Adjustor and Placator (these role titles have since been replaced by Sharon Wegsheider-Cruse's equivalent titles: Hero, Rebel, Lost Child and Family Mascot). These relate, generally, to the birth order of children in the family.

The oldest child is the Hero or Responsible Child. This is, usually, the very responsible child who tries to place some structure in the family and takes on the parenting roles, not only for younger siblings but, also, for the parents, if necessary, as well as household duties etc. This child seldom misbehaves and achieves well at school. Even in a family with only one alcoholic, where the coalcoholic (the alcoholic's spouse) may provide some parenting

ıd family structure, this role still emerges in the oldest child as, typically, the

co-alcoholic will share responsibility with this child and will treat the child as an equal adult, as one would treat a spouse. The co-alcoholic usually has their hands full looking after the alcoholic, so the Hero is forced to look after the rest of the family.

The next eldest is usually the Rebel or Acting-Out Child. These children often display the problematic delinquent behaviour. The irony of this role is that it more accurately typifies the state of the family, i.e. chaos.

The third eldest is usually the Lost Child or Adjustor. These children simply adjust to whatever situation occurs and tend to remain in the background. They live in their own world of fantasy be it imaginary, television, work or school. The reason is that there is already a family structure provided for them by the Hero or parents and they don't have to take responsibility for themselves - they just work in and try not to 'rock the boat'.

The fourth eldest usually becomes the Family Mascot or Placator. These children are very warm, sensitive and caring people (indeed many end up in the helping professions).

They act to ease any pain the family may feel, as if it were their own pain. These children are skilled listeners and adjudicators, so people tend to come to them for advice. Mascots often end up rescuing these people - aking responsibility for the way others feel and trying to lessen their anger or

pain.

It should be pointed out that these roles are not fixed to birth order, but research suggests this is the most common pattern. Still, the hero role seems to be the most fixed because it relates to responsibility in a family and the eldest child, in the home, is the most likely to shoulder this responsibility. The other three roles are far more fluid.

Running through these roles is a common pattern of avoidance. Avoidance of what is really happening at home, avoidance of what is happening to me, with my feelings.

This is called, perhaps more accurately, denial and is the psychological mechanism that allows these roles (and the entire alcoholic family) to exist. It is best summed up in three statements, "Don't talk, Don't trust, Don't feel". These three messages are perhaps one of the few consistent things about the alcoholic family, and are fed both overtly and covertly to children as part of their family life.

"Don't talk" relates to talking about real issues such as "Mum is drinking again" or "Dad hit me" rather than "I got this bruise from walking into a door". The children are told that to be good they must cover up reality.

"Don't trust" - COA's have learnt, through early abuse of trust by the family, that the only person they can rely on for everything is themselves. This abuse of

trust arises from inconsistencies in parenting.

"Don't feel" - the alcoholic's law of "Don't talk, Don't trust" teaches children it isn't safe to share feelings and so they deny they have feelings for themselves. They can sometimes, as in the placator role, project these feelings so that they feel for others (e.g. I feel scared for Mum or Dad but not for me).

As these children grow up they have major gaps in their psychological and emotional make up. These gaps are issues related to trust, control, dependency, identification and expression of feelings. These issues affect the ACOA's in:

1) involvement in relationships and particularly intimate ones,
2) can lead to depression, or
3) continuance in an alcoholic or dysfunctional system via marriage,
4) progression of one's own alcoholism.

The Hero as an adult is usually a person who can get things done, is articulate and ends up the epitome of success. They also have a great need to be in control and tend to be inflexible. They find it hard to relax because as children they couldn't - they had, and still have to be responsible. Heros see things as black and white with no in-betweens. In relationships they either find someone they can control or remain alone. Fun-loving, open, caring people are too scary to handle.

As a result of their childhood Rebel adults find they lack education and job skills, find it hard to control their anger and thus, find it hard to get and keep jobs. They often start drug taking and drinking at an early age. As a result Rebels feel powerless over their lives and usually end up in jail, on the dole or prematurely dead, due to alcoholism/drug addiction.

As adults, Lost Children avoid their own reality and emotions by being super-flexible, because as children they never had the chance to develop trust or a sense of control. However, they did develop flexibility and spontaneity. As such, Lost Children find it hard to see choices, set goals and make decisions. They also find it hard to settle, be it physical, emotional or spiritual. Life seems like a perpetual roller coaster to these ACOA'S.

The Placator ends up only feeling good about themselves when they can help others. They have a natural ability for empathy and listening and so usually make good social workers, psychologists, psychotherapists, nurses and counsellors - this way they can avoid dealing with what is present inside them, by helping others.

Because of their difficulty in experiencing feelings all ACOA'S, no matter which role they take, may turn to alcohol or other mood-altering drugs, which help to overcome their inhibitions and give a temporary boost in self esteem.

This association of using alcohol and feeling good makes ACOA's prime candidates for alcohol dependency.

Until now the book has concentrated on describing the process of growing up in an alcoholic home, the roles people take and how it affects them as adults.

From this point "It Will Never Happen to me" becomes a self-help manual. one chapter looks at the child in the home and is designed to help the co-alcoholic to help their children, the next chapter is designed to help ACOA's as adults and a third chapter looks at family violence.

The child orientated chapter has a section describing alcoholism, which looks at denial, enabling, blackouts, personality changes, broken promises and relapses. This is done so the child can understand what is really happening to both them and their parents, in the home and how they can change themselves effectively despite their age and situation. This chapter also has a section on simple problem solving.

Apart from the above the child and adult chapters look at the same issues, but with a differing emphasis, as befits their target audience, as such these chapters will be dealt with at the same time.

Dr. Black explains that when ACOA's first enter therapy they must go through a grief process - grieving the loss of their childhood: they deny there is

a problem at first; they then realise there is a problem, this is accompanied by feelings of sadness and/or fear; they get angry at the alcoholic; they blame themselves for the alcoholic's problem; they finally feel guilt and may get depressed as they seek a resolution to their problem(s). Black affirms this is a normal process and that the child or adult must be allowed to share their feelings and go through this process fully to get over the guilt and find a resolution.

Both chapters then look at acknowledging and expressing feelings - particularly anger, guilt, fear - and the ability to cry. Then there is a section, in both chapters, on the reshaping of roles with some simple activities ACOA's can do to help them adopt healthier behaviours.

The next chapter examines violence, both physical and sexual. Black points out the similarities between a batterer and an alcoholic or co-alcoholic - both deny the severity of their problems and both give out messages of "Don't talk, Don't trust, Don't feel". Both abuse and alcoholism can occur in the same family but may involve different parents. ACOA's often marry batterers.

Black then gives advice to help professionals on how to handle abuse cases, such as, assessing possible abuse (sexual or physical) in a family and how and when to refer. This section helps put the alcoholic family in the context of just one of a number of possible dysfunctions a family can suffer. Although

they all share a similar family process, as outlined in this review, because of the nature of alcoholism and the strength of the denial, the alcoholic home is certainly one of the severest family dysfunctions.

The final chapter looks at the resources available to anyone who may want help in the addiction field, either as a therapist or a client. Although this is comprehensive it is designed for the American audience but, fortunately, many of the services are replicated in New Zealand, for example A.A.

A possible criticism of this book is that it is based on clinical experience with little real research to back up Black's claims of the alcoholic family process. However, there has been since "It Will Never Happen to Me" was published, a general acceptance of this process by both therapists and authors within the addiction field. So much so that book shops are now full of books on ACOA'S.

In conclusion, this book offer a stunning insight into alcoholism and families of alcoholics. It is written well and is very readable. This book packs a lot of detail into its 200 pages. It is recommended reading for anyone who wishes to help others or themselves.